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Towards an Understanding of Nurses Leaving Nursing Practice in China

**A Qualitative Exploration of Nurses Leaving Nursing
Practice from Recruitment to Final Exit**

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PhD

The University of Edinburgh

2012

Declaration

I declare that this is my own work. Any information published as well as unpublished materials I used to support arguments in this thesis, I have referenced where appropriate.

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18th July 2012

Preface

“If there is one lesson to be learnt, I suggest it is that people must always come before numbers. It is the individual experiences that lie behind statistics and benchmarks and action plans that really matter, and that is what must never be forgotten when policies are being made and implemented. ” (Francis 2010:4)

Robert Francis QC
Chairman of Independent Inquiry into care provided
by Mid Staffordshire NHS Foundation Trust
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Abstract

The nursing shortage in China is more serious than in most developed countries, but the loss of nurses through their voluntarily leaving nursing practice has not attracted much attention in Chinese society. The aim of this study is to add to the understanding of nurses leaving nursing practice in China by exploring the process from recruitment to final exit. The qualitative research method draws on a grounded theory approach, especially the constant comparative method of analysis. The in-depth interviews were conducted with 19 nurses who have left clinical care. The selection of the study participants was guided by the principle of theoretical sampling. Two core conceptual categories emerged from leavers' account of their leaving: "Mismatching Expectations: Individual vs. Organizational" and "Individual Perception of Power". By illuminating the interrelationship between these two core categories, four nursing behaviour patterns are identified: (1) *Voluntary leaving* (2) *Active staying* (3) *Adaptive staying* (4) *Passive staying*. These behaviour patterns provide an explanation about why and how nursing wastage occurs. The analysis suggests: (1) the higher the degree of mismatch that the nurses recognised between individual and organizational expectations of nursing and the greater the extent of imbalance of power the individual nurses perceived, the more likely it is that the nurses intend to leave the powerless status of being a clinical nurse within the organization; (2) the more difficult it becomes for the nurses to achieve their individual expectations by exercising nursing autonomy in their nursing career, the more likely it is that they actually empower themselves to leave nursing practice. The study suggests that nursing wastage could be avoided if the individual and organizational expectations of nursing were more aligned, and the individual nurses were able to exercise nursing autonomy in their professional practice and career. Although the findings are limited in studying the current nursing workforce situation in China, the theoretical perspective may contribute to the international debate on nursing employment towards effective nursing workforce management and retention strategies.

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Introduction

1. Background of the study

The world health organization warns that the nursing shortage directly influences the quality of health service and patients' mortality (WHO 2006). However, despite a more serious nursing shortage in China than in many other developed countries, the loss of nurses through their voluntarily leaving nursing practice has not attracted much attention in Chinese society.

In the past three decades, Chinese nurses have experienced rapid and unpredictable economic, social, political and educational changes under the Chinese health system reforms. These changes have greatly impacted on the quality of health care, the well-being of nurses, and accordingly, have influenced nurses' employment decisions. Currently the Chinese public are greatly dissatisfied with the high cost and low quality of health care (Ma *et al* 2008, Hsiao 2008). The Chinese Nursing Association (CNA) hopes the backlash of a national nursing shortage and subsequent negative effects on patient outcomes in China will be the ultimate trigger for Chinese healthcare reform and will improve the welfare of Chinese nurses (Anand *et al* 2008, Hu *et al* 2010). However, although the CNA calls for policy makers and hospital managers to concentrate on recruiting and retaining as many nurses as possible (MHPRC 2005), the nursing shortage and workforce problems were not considered a relevant and important issue in the current pilot stage of the new health care reform, which was launched in 2008 (MHPRC 2009). The CNA currently has provided overwhelming support for Chinese nurses to work abroad (Xu 2003, Kingma 2006, and Fang 2007). One of reason for encouraging emigration of nurses was explained by the leadership of the CNA; that they hope the issues created by departing nurses can serve as a wakeup call for the hospital managers to rethink and re-evaluate the social and economic worth of nurses (Xu 2003, Hu *et al* 2010). International outflow in China may be very visible but still represents only a relatively small numerical loss compared with internal flows of nurses leaving nursing practice for other

sources of employment. However, the Chinese nursing leavers were used to keeping quiet individually, and left the problems they encountered without raising a collective awareness, which prevents the CNA from addressing the root causes of current workforce problems and domestic nursing shortage.

As Mackay (1989) advocates, if worthwhile nursing workforce policies are to be framed by the policy makers, they need to be informed of the problems that nurses encounter and create in their nursing career and understand how these issues impact on the health care system. The Chinese nurses who voluntarily left nursing practice have rich experiences which cover the whole career process from recruitment to final exit. What they have to say can serve as a bridge for nurses to effectively communicate the nursing workforce problems with policy makers and hospital managers. I initiated the study with the intention of contributing towards an understanding of nurses leaving nursing practice when the Chinese pilot health reform started in 2008.

The Chinese pilot health care reform was on going at the same time as this study was being carried out. The Chinese Hospital Association has reported that the rate of accidents in the Chinese hospital increased from 2003 to 2008, and the highest rate of accidents was among the top hospitals (Grade three hospitals¹). This information of concerns relating to safety was recently released by the Vice Minister of Health (Ma 2010b). However, the validity and reliability of these statistics is still debated among the health authority, hospital administrators and medical staff, since the nationwide accident reporting system lacks transparency and consistent monitoring and is only based on a voluntary reporting system (Chen 2009, Ma 2010b). Nevertheless, the Chinese government admitted that the previous health care reform has not

¹There are two tiers of Grade three hospitals. The first tier has the highest educated medical experts and nursing staff, and the best technical facilities and these hospitals are regarded as the best in Mainland China. These criteria in personnel and facilities for advanced medical treatment and tertiary care may be similar to the tertiary referral hospitals in US or UK health system, but the Chinese Grade three hospitals are widely accessed by patients without a referral from a primary or secondary health professional, such as the GP system in UK. The term “Grade three hospital” used in this study means the first tier of Grade three hospitals.

successfully resolved the issues of safety and cost efficiency of health care in China (Ma *et al* 2008, Hsiao 2008). Under public pressure, the public hospitals reform has become the priority agenda of the new health reform, which aims to “improve the harmony of Chinese society” (MHPRC 2011a). The new health care reform in China was enacted nationally through the investment of 850 billion Yuan (\$124.26 billion) in the following three years, but issues relative to a sustainable nursing workforce were obviously an omission (MHPRC 2009).

The Chinese Government has made a public promise that patients should only be cared for by qualified nurses and plan to stop all hospitals from using less qualified carers and patients’ private hired helpers (MHPRC 2010c). However, this plan to stop the use of unqualified carers has met strong resistance from the hospital administrators and nursing managers, since these less paid and unqualified carers have been used to supplement the reality of the nursing shortage within the hospitals in order to save hospital budget (Li 2010). To address this situation, the Ministry of Health has clarified that the previous declaration did not intend to make it compulsory to stop patients hiring private helpers if patients were willing to do so, but reinforced that nurses should work hard to take the responsibility for patients’ satisfaction without a clear understanding of nursing staffing issues (Ma 2010a, Gou 2010). The Ministry of Health compulsorily implemented a national “Excellent Care Service” project through selecting one or two units within Grade three hospitals and some Grade two hospitals. The project aimed to demonstrate that high quality of health care and high patient satisfaction could be achieved by using only qualified nurses (MHPRC 2010c). Meanwhile, the Ministry of Health published national guidelines for nursing clinical practice, in which they repeatedly emphasized that nurses should concentrate on providing basic care for “the satisfaction of the patients, the society and the government” (MHPRC 2010a, 2011b). Without effective discussion of the nursing workforce problems with the policy makers, these guidelines and the goal of meeting the “three satisfactions” were accepted by the leaders of CNA as the priority of nursing practice in the hospitals (Gou 2010).

While the health ministry formally praise the successes of the “Excellent Care Service” projects, the undeniable negative effects attracted nationwide media attention on the International Nurses’ Day (Li 2010). The goals of this project, its feasibility and sustainable achievement have been widely questioned by clinical nurses. The individual nurses’ complaints and negative comments are only temporarily available on line. Several local media websites released news that small groups of nurses went on strike during 2009 to 2011. The reports usually used supportive evidence from the hospital managers and the patients, but did not carry detailed opinions from nurses who were on strike, nor any comment from nursing professional bodies. Therefore these opposite views appear anecdotal, without reliable evidence sources².

As my study progressed, the safety issue became one of the participants’ main concerns in their leaving process. These participants who left nursing practice are in the best position to express their views freely, with less constraint, than their nursing leaders and colleagues who are still working within the Chinese health care system. At that time, managers and local health authorities were still in chaos and questioning the reliability and validity of national hospital accidents’ report about the safety and quality of care among the Grade three hospitals. I decided to limit the participants of my study only to those who previously worked in the Grade three hospitals, since I hoped their experiences and thoughts would shed new light on the safety and quality issues in these top hospitals for the hospital managers and policy makers.

To develop the pilot health care reform into the next stage, from 2012, the Chinese government has committed to seeking effective suggestions and improving the

² The online comments from clinical individual nurses are usually available at the commercial nursing website which belongs to the agencies working for nursing immigration. A few nurses’ comments, available on the local or national nursing association websites, are usually no longer available overnight if the comments tend to be negative. For example, “Where is my yesterday comment? This is the space for our nurses to communicate each other, right? It disappeared today? You did not allow us to speak the truth!” “We are welcome positive comments on our nursing association website, but it is not for you to make it negative.” (Online conversation observational field notes 2010 Feb 2).

quality and cost efficiency of health care (Fang 2007, Chen 2009, MHPRC 2009 and 2011a). There is interest among the Chinese Government legislators in working together with multi-disciplinary researchers. During this crucial time, the findings of the study will provide an explanation and understanding of nursing workforce issues and how these issues impact on the current health care system in China from the perspective of nurses. The study hopes to build an effective communication bridge between nurses, policy makers, hospital managers, and support the CNA in initiating nursing retention strategies towards resolving the nursing shortage in China.

2. Structure of thesis

Chapter 1 Literature Review The study is defined by comparing the reality of nursing shortage and current strategies in resolving the shortage problem in both China and other countries of the world. The critical literature review indicates that Chinese nurses face unique historical, political, cultural and educational difficulties in trying to resolve the problem of the nursing shortage. There is a need to understand and communicate why nurses leave nursing practice in China and how this issue impacts on Chinese health care in order to initiate retention strategies to resolve the Chinese nursing workforce issues.

Chapter 2 Research Design This qualitative research is based on the theoretical perspective of symbolic interactionism. The study draws on the earlier works of Glaser and Strauss, especially the constant comparative method of analysis and the flexibility that the grounded theory approach allows. In-depth interview with the leavers was chosen as the most effective method to collect data. The procedure of finding the interview participants was guided by the principles of theoretical sampling.

Chapter 3 Entering Nursing with Unrealistic Expectations The data shows that the participants chose nursing study under the influence of collective expectations. It appears that this is not a problem for nursing students' recruitment under the current

expansion of higher education in China. However, the unrealistic pre-entry expectations of nursing are continuing throughout their nursing education, although Chinese nursing education has changed historically. These unrealistic expectations have resulted in a great wastage in different levels of nursing education.

Chapter 4 Working in the Ideal Workplace The data shows employment in the Grade three hospitals are regarded by Chinese nurses as the ideal workplace under the unequal Chinese Health Care System. These hospitals attract the most excellent graduates in an over supplied job application pool by going through strict selectivity, which has forced the recruits to tolerate discrimination and accept different contracts according to organizational recruitment criteria. However, under a profit driven motive, the priority of Chinese hospital is to achieve the largest profit. The participants expected to do a good job in caring for patients and felt frustration despite working in the ideal workplace, since the hospital did not employ the well qualified nursing workforce effectively without a clear role boundaries and effective ski-mix team work. These working experiences caused a negative impact on their enthusiasm in a nursing career and struggling with nursing professional identity. Participants established an organizational commitment earlier than a nursing commitment.

Chapter 5 Losing Confidence in the Safety and Quality of Health Care The data shows all participants, both experienced and inexperienced nurses, felt frustrated when the safety and quality of patients' care could not be achieved by their individual efforts. However, nurses had to work hard but keep quiet as they were required to maintain organizational loyalty. Concern over issues of safety and quality without proper organizational support became the main reason for nurses leaving the profession.

Chapter 6 Conflict with Doctors The data shows misused antibiotics, excessive medication and over-use of advanced equipment and techniques currently created an ethical dilemma for nurses, who needed to implement the treatment of patients under

medical orders although in sympathy with the situation of patients. Nurses had to adjust their nursing behaviour according to their perception of the nursing autonomy under medical dominance within the current health care environment. Some of them felt guilty to be a nurse, because they could not protect patients' properly due to medical dominance in their daily nursing practice; while others re-evaluated their ambitions and capabilities and retrained by becoming a doctor or a representative of pharmaceutical company for the financial benefits. This caused public suffering and inevitably negatively affects social stability and harmony. These unresolved conflicts between nurses and doctors pushed the nurses who were more acutely aware of nursing autonomy under medical dominance into leave nursing practice.

Chapter 7 Lack of Management Support The data indicates that nurses are regarded as replaceable labour. The professional value and contribution of nursing was not appreciated by nursing managers and hospital administrators. Hospital managers emphasised that leaving is an individual loss rather than an institutional problem. Powerless nursing managers adopted strict regulations, procedures and examinations as ways of nursing evaluation for reasons of promotion and career progress. Participants gave up their efforts when they felt unable to struggle and meet the strict requirements according to the medical career progress path criteria without gaining more respect and appreciation of the value of nursing.

Chapter 8 Meaning of leaving nursing practice The data shows that Chinese nurses do not have opportunities to find the most compatible nursing practice environment, where they could expect to achieve their best personal and professional development, due to the lack of nursing workforce mobility between units, hospitals and countries. Furthermore, sick leave and maternity leave have been limited to a minimum. Chinese nurses are acutely aware that leaving nursing practice usually means eternally leaving a nursing career. Under the organizational control, the ideal workplace became a trap to keep some nurses staying in nursing for life by adjusting their expectations of nursing, which cause great wastage of nursing. When the individual nurses lost hope of achieving their individual expectation in their nursing

career, some of them feel enabled to leave the powerless status of being a clinical nurse for personal freedom.

Chapter 9 Discussion and Conclusion The last chapter draws together all the threads based on illuminating the interrelationship of the two core conceptualised categories, “Mismatched Expectations: Individual vs. Organization” and “Individual Perception of Power”. The study has clarified the importance of understanding nursing wastage in resolving nursing shortage. By developing two hypotheses along with the four nursing behaviour patterns voluntary leaving, active staying, passive staying, and adaptive staying, the study provides a new theoretical perspective to explain and understand why nurses voluntarily leave nursing practice in China and how the nursing wastage happened. The theoretical understanding also provides retention suggestions towards an effective nursing workforce with practice and policy implications.

Chapter 1 Literature Review

1. Introduction

A computer-based literature search was carried out using the following databases in Chinese and English separately: CNKI, CINAHL, EBSCO, Medline, Blackwell, Science Direct, British Nursing Index, PsychINFO, Business Source Premier and Google Scholar. I adopted two different approaches of critical literature review during the study.

Before the review board, the following key words were used individually or in a combination to elicit the pertinent research articles from 1995 to date: nurse/nursing, shortage, turnover/leaving, health workforce policy/ staffing regulation, recruitment/ retention. Two websites, the Ministry of Health of the People's Republic of China (MHPRC) (<http://www.moh.gov.cn/>) and the WHO health workforce (<http://www.who.int/hrh/en/>), were used to access extra databases, update the relevant policies, documents and news relating to the nursing workforce management.

A further literature review was delayed until the core conceptualized categories emerged from the data analysis. The new key words, which were based on the research findings, were added to previous search strategies in order to pursue wider and more focused literature. Extra theses and conference papers which have particularly contributed to nursing workforce retention were retrieved following the key researchers internationally. By joining the Global Health Workforce group on line discussion (<http://www.linkedin.com>), this provided an opportunity for me to update the literature by discussing and sharing ideas with the experts who are involved in health care workforce plan or research from different disciplines and from different countries.

The result of these searches revealed that the majority of English language literature which is relevant to nursing shortage and nurse turnover is from the USA, while the remainder comes from other industrialized countries. Very few studies are available from developing countries, including Mainland China. This literature chapter will mainly focus on discussing the first stage of literature review and a more focused literature review as second data will be integrated in the discussion chapter. The purpose and strategies of using the literature will be explained later in the research design chapter.

2. The nursing shortage worldwide and in China

The nursing shortage is a worldwide problem (WHO 2006). The WHO warns that it is directly influencing the quality of the health service and patients' mortality and advocates that every country, poor or rich, should have a strategic national workforce plan (WHO 2006). Essentially, a shortage is defined as an imbalance between the nursing requirements and the actual available nurses (Zurn *et al* 2002).

The distribution of health workers in different countries has provided an overview of the nursing workforce imbalance in the recent decade (Table 1). The United States has the biggest registered nursing pool and a relatively high number of other health workers compared to those of other countries, but the shortage of nurses is still estimated about 1 million by 2015 (Aiken and Cheung 2008). Although the Chinese health workforce has slightly increased and exceeded the WHO minimum workforce threshold from 2001 to 2006 (WHO 2006), China is one of a few countries in the world with more doctors than nurses, and this gap continues although the Chinese government has declared it will try to control the ratio of doctors to nurses to 1:1 by 2012 (MHPRC 2005). This raises questions about public investment in training and deployment to achieve the most cost-effective health service (WHO 2006). The population-based indicators (Table 1) clearly demonstrate a more serious nursing shortage in Mainland China than most developed countries. The inadequacy of

nursing staffing has resulted in a far more demanding clinical situation in Mainland China than in most industrialised countries.

Table1: The distribution of health workers in selected WHO member countries

Countries	Physicians	Nurses		Ratio of nurses to patients		Other health workers ³	Years	Sources
	Density per 1000 population	Density per 1000 population	Number	Day shifts	Night shifts or holiday shifts	Density per 1000 population		
Mainland China	1.06	1.05	1,358,000	1:15-20	1:40-45	0.82	2001	(1, 4,5)
	1.55	1.11	1,426,339				2006	(1,2)
	1.40	1.00	1,301,240				2008 ⁴	(8)
	1.42	1.38	1,854,818			0.83	2011	(9)
India	0.60	0.80	865,135				2003	(1,9)
	0.60	1.30	1,430,555			0.50	2011	(8)
Japan	1.98	7.79	993,628				2002	(1)
	2.10	9.50	1,210,633				2008	(8)
	2.06	4.14	531,210				2011	(9)
UK	2.30	12.12	704,332	1:7.5-7.6	1: 9.1-10.7	2.78	1997	(1,6)
	2.30	12.80	740,731				2008	(8)
	2.74	10.30	621,755				2011	(9)
USA	2.56	9.37	2,669,603				2000	(1)
	2.60	9.40	2,669,603	1:5	1:5	14.66	2008 ⁵	(3,7)
	2.67	9.82	2,927,000				2011	(9)

Sources: (1)WHO 2006 (2) Chinese Health statistic Digest 2006-2007 (3) Aiken and Cheung 2008 (4) Ren 2001 (5) Liu *et al* 2003 (6) Employment Research Ltd 2007 (7) Conway *et al* 2008 (8) World Health Statistics 2008 (9) World Health Statistics 2011

The government statistics need to be treated with caution since their reliability and validity lack consistent monitoring. Lewis (2002) further suggests that the shortage is not merely about numbers, but also a matter of how these numbers are most

³ The other health workers in USA include 510,000 licensed practice/vocational nurses (LPS) and 1,474,000 nursing assistants who support the 2,417,000 registered nurses.

⁴ The number of Chinese nurses was reported as 1,543,000 in 2008 by the Ministry of Health of the People's Republic of China (MHPRC2008), and the ratio of doctor to nurses was recently reported as 1.16:1 in 2010 (Xinhua News 2011.4.28), which is inconsistent with the WHO statistics (2008, 2011), but there is lack of evidence to prove which is more reliable.

⁵ It is surprised that the number of American nurses in 2008 is reported as same as in 2000 by the WHO, while it is reported as 2,417,000 by Aiken and Cheung (2008).

effectively deployed in the health care system. In reality, there is a shortage of nurses willing to work under the present conditions (Buchan 2006). Some Japanese nursing researchers highlight that about 650,000 (about 53.7%) inactive nurses existed in Japan in 2008 (Nakata and Miyazakis 2008). Although there is a lack of follow up reports from Japan, the forecast and its possible consequences might explain a sharp decline of Japanese nursing workforce in 2011 (Table 1). It is also said that only 40% of the total nursing workforce is active in India, because of low recruitment, immigration attrition and drop-out due to the poor work conditions (Government of India 2005). From the statistics, it is hard to say which countries could resolve the nursing shortage by comparing the increasing trend of nurses in India, China⁶ and USA with the decreasing trend of nurses in Japanese and UK. The reliability and validity of health workforce statistics needs to be examined by the policy makers if they wish to create effective nursing workforce employment.

Over the past decade, a high rate (over 70%) of intention to leave nursing has been reported in different areas nationwide in China (Sun *et al* 2001, Ye *et al* 2006, Lu *et al* 2007). Chinese nurses have continued to leave nursing practice (MHPRC 2005, Mao and Wang 2006), but there is a lack of official statistics to monitor how many nurses actually left. Meanwhile, consistent evidence shows that about 9-15% of qualified nurses, whilst working in Chinese hospitals, are not employed as nurses (Yang and Chen 2004, Liu *et al* 2005). These inactive nurses have exacerbated the shortage in China. A high nurse turnover rate not only negatively impacts on the quality of care, but also affects the morale of nurses and reduces their productivity when new staff members are hired (Shields and Ward 2001). However, this well-accepted view in the West is ignored in China.

⁶ Mainland China was simplified as “China” afterwards in this thesis. It specifically means the People’s Republic of China. The WHO health statistic reports the distribution of health workers in China, but they have not included the information on Hong Kong and Macao, two special administrative regions of China, nor the information from Taiwan. The nursing literature on turnover in these specific regions indicates that the reasons for nurses’ turnover in Hong Kong, Macao and Taiwan maintain a certain similarity to those of the western countries of which they were former colonies countries (Chen *et al* 2008, Chan *et al* 2009, Chan and Lai 2010). However, the systems of nursing education, personnel recruitment and health care management in these regions under their local government authority are much different to those of Mainland China within the Chinese Central Government administration.

3. Responses to the nursing shortage in western countries and in China

The mainstream studies on the nursing shortage and turnover from western countries declare that the reasons for the growing shortage of nurses are similar elsewhere (Tierney 2003), including the declining enrolment, the aging workforce, changing work climate and poor image of nursing (Aiken *et al* 2001, Goodin 2003, Black 2005, Estabrooks *et al* 2005). There is a clear agreement in these countries that solving the nursing shortage is wholly dependent on cooperation between the government and the nursing profession, which includes encouraging recruitment by a broad recruitment base, improving retention, attracting former nurses back into the profession and increasing international recruitment from abroad (Sheilds and Ward 2001, Buchan 2006, Rafferty *et al* 2007). Different strategies to retain their nurses have been actively adopted by Western hospitals (Aiken *et al* 2001, Finlayson *et al* 2002, May *et al* 2006). The common interventions include employing temporary staff and increasing pay and benefits as short-term strategies; with increasing nursing education investment, improving the working environment and flexible work schedules as long-term strategies (*Ibid*).

Although nursing shortage is more serious in most developing countries than in the developed countries, there are only a few nursing shortage studies in developing countries, which mainly focus on immigration, including Mainland China, India, Philippines and most of African countries (Fang 2007, Aiken and Cheung 2008, Buchan 2008, Gill 2011). This situation may be partly due to the nursing workforce researchers who are mainly from the developed countries and the weakness of research capability among the nursing researchers in the developing countries. Nevertheless, the ethical issues in international recruitment have been well debated in the West, mainly based on the studies in African countries, since even minimal numbers of migrants represent significant losses in some small countries with scarce nursing human resources (Dovlo 2005).

On the contrary, international recruitment predicts that China will become an important source of nurses for developed nations (Xu 2003, Kingma 2006, Fang 2007). Although the former nurses are attractive to the government in many countries because they appear to offer a relatively quick, effective solution to the nursing shortage (Buchan 2006), currently there is a lack of feasible strategies to retain and attract nurses back to nursing in China (Fang 2007). For resolving nursing shortage, the Chinese government mainly focusses on increasing nursing education and achieving nursing staffing within *dingbian*⁷ (MHPRC 2005).

4. Strategies for resolving the nursing shortage in China

4.1 Nursing recruitment in the Chinese educational system

Nursing education in China includes diploma, associate degree, bachelor degree and postgraduate education (Table 2). Although nursing is still perceived as a less desirable career (Xu *et al* 2000), under the government's strict occupational distribution control, being transferred from other majors is listed as the top reason for choosing a nursing career (Zhou 2004). It is difficult for students to change their major once admitted to nursing studies (Xu *et al* 2000).

Along with current Chinese higher education expansion, the enrolment of higher levels of nursing education shows an increasing trend from 2001 to 2010 (Table 3). However, a great loss of Chinese nurses after graduation has been mentioned by Fang (2007) and Xu (2003). Anand *et al* (2008) found an excess of 981, 000 health workers graduating from all Chinese health educational institutions who were not counted as part of the health workforce from 2000 to 2005 by the Ministry of Health database. But this report is not specifically about nurses; there is still lack of reliable

⁷ *Dingbian* is a staffing quota formula within the Chinese personnel management system. It establishes the national health personnel management standard in Chinese National Health Service, which was original issued in the Protocol of Hospital Personnel Establishment Framework by the government in 1978 (MHPRC 1978). It limits the numbers of all types of hospital staff per bed based on the size of hospitals and the ratios of doctors to nurses are recommended.

official statistics on how many nurses were lost after graduate in China. Meanwhile, Chinese nursing recruitment currently faces challenges, since the Chinese government has not only cut the budget for nursing training but also underfunds the hospitals employing the trained nurses (Wu and Zhang 2000, Fang 2007). It might be too optimistic for the government to declare that the nurse shortage is being addressed based on the increasing trend of nursing numbers statistics.

Table2: Multilevel nursing education and nursing workforce in China

Types of programme	Age of entry	Years of study	Percentage of the current workforce	Percentage of all new recruits
Diploma	15-16	3	85-95%	70%
Associate degree	18	3	4-8%	23%
Bachelor degree	18	4-5	6%	8%
Postgraduate education (Master degree and Doctorate Degree)	<35	3	(Unavailable)	(Unavailable)

Table3: Chinese nursing school recruitment plan2001-2010

Types of programme	2001		2005		2010	
	number	%	Number	%	number	%
Diploma	75,000	71	88,000	62%	82,200	50
Associate degree	25,000	23	38,200	27%	49,200	30
Bachelor degree	6,500	6	15,100	11%	32,000	20
Total	<106,500		141,300		164,300	

Sources: MHPRC 2003 and 2005

4.2 Historical reality of *dingbian* and nursing employment in Chinese Health system

In 1978, the Chinese government established *dingbian* as a staffing legislation in the Chinese Health system. The staffing requirements in *dingbian* focus on the numbers of all types of hospital staff per bed based on the size of the hospitals and the ratio of

doctors to nurses is recommended (Table 4). It is different from the current international nursing staffing policy in most western countries, which focuses on the number of patients per nurse based on the work-unit (Rafferty *et al* 2007, Aiken and Cheung 2008, and Conway *et al* 2008)(Table 1). From 1979, the Chinese health-care system gradually transferred from a planned to a market economy (Hsiao 2008). Since then, the State subsidy has been cut annually, from 30% to less than 7% of total hospital expenditure (Blumenthal and Hsiao 2005).

Table4: The discrepancy between *dingbian* and actual staffing in Chinese NHS

The ratio of staffing (numbers of all health staff to beds)	Hospital size (number of beds)			Average ratio of nurses to beds	Ratio of doctors to nurses	Sources
	<300	300-500	>500			
<i>Dingbian</i>	1.30-1.40:1	1.40-1.50:1	1.60-1.70:1	0.4:1	1:1.5-2.0	MHPRC 1978
Actual ratio of staffing (Zhejiang Province)	1.32:1	1.33:1	1.53:1	<0.4:1	>1: 1.5	Liang <i>et al</i> 2007
Actual ratio of staffing (Nationwide)	Unavailable	Unavailable	Unavailable	0.33:1	1:2.28(1952) 1:1.09(2001) 1:0.68(2003)	MHPRC 2005

Based on the political and economic health care reform, three decades after *dingbian* was implemented, few hospitals achieve the staffing ratio of *dingbian*, and they all strictly limit nursing staff, yet unreasonably increase doctors over nurses (WHO 2005, MHPRC 2005, Liang *et al* 2007) (Table4). Meanwhile, in contrast to Western countries, the quality of care was not properly evaluated and made accountable to the public, due to a lack of valid monitoring mechanisms in Chinese hospitals (Wu 1997, Ma *et al* 2008). The hospital managers are reluctant to admit that nurses are important to the quality and safety of care based on a profit motive driver (Hsiao 2008).

Although *dingbian* has been treated as flexible legislation by the government and hospitals, it has been taken for granted by hospital managers to control nurse employment. Most hospitals only recruit a few new graduates with bachelors'

degree within *dingbian* and force most other nursing students to accept unfair contracts without *dingbian*, which means that they do the same job but with fewer benefits and less job security than their colleagues (Fang 2007). Meanwhile, lots of workers without nursing training are privately hired to care for the patients (Zhang and Petrini 2008), which is one of the reasons why there is both a severe shortage of nurses and high nurse unemployment in China (Xu 2003, Fang 2007). Consequently, age and appearance discrimination are rife in Chinese nursing recruitment (Zheng and Wang 2006, Fang 2007).

Dingbian continues to be cited in the First State Nursing Law as the main strategy for resolving the nursing shortage in 2008 (Wen 2008, Gou 2008). There is a lack of evidence from nurses' perspectives to demonstrate how the nursing employment policy impacts on their work environment, the patients' safety, and accordingly influences their career decision making, since Chinese nurses are constrained in sensitive power relationships within the health system.

5. Power relationships in the Chinese health care system

Chinese nurses express a sense of powerlessness regarding their ability to influence the doctors, managers in decision making (Sun *et al* 2001, Pang 2003). Although there is little nursing research to tackle how power relationships interact within the Chinese health care system, a qualitative study, which was carried out by Swedish researchers, describes the ethical dilemmas of Chinese nurses that they are expected to remain loyal to the doctor, even when the doctor makes a mistake (Tang *et al* 2007). Meanwhile, they try to care for the patients, but can receive unfair criticism and blame (Tang *et al* 2007).

Despite the dilemmas, Chinese cultural norms emphasize collectivism and self-interpersonal harmony (Li1995). Just as Harrinson *et al* (1992) explains, Chinese nurses rationally choose not to initiate conflicts because the time and energy needed may make the costs of challenging authority too high. Chinese nurses who are in

conflict with their work unit, managers and colleagues may suffer a loss of status and material benefits (Li 1995). The CNA cannot act for nurses' rights as professional representation (Pang *et al* 2000, Xu 2003), and there is a lack of a nursing trade union in China. As Lukes (2005:27) notes, "by influencing, shaping or determining his very want, to secure their compliance by controlling their thoughts and desires", the medical, social, political and cultural elements exercise power over nurses. Consequently, Chinese nurses accept their role as unchangeable (Fang 2007).

Under such demanding and powerless working conditions, when job mobility has become a reality in Chinese labour market since 1995(Hsiao 2008), Chinese nurses continue to leave nursing practice. Many nursing educators assume that nurses leave due to incompetence, earlier age of entry or lack of obligation to society (Jiang 1997, Sun *et al* 2001, Liu *et al* 2002), but they ignore the reality that it is not always the best nurses who are staying (Xu *et al* 2003). Several studies found that the nurses with a bachelor degree and associate degree report a higher intention to leave than that of nurses with a diploma (Wu and Zhang 2000, Lu *et al* 2007). The immigration researchers also indicated that usually the group of Chinese nurses who chose to work abroad were highly experienced and well qualified (Xu *et al* 2003, Fang 2007). Gill (2011) advocates that the impact of immigration should be understood from source country perspectives, and then efforts could be made by the government to retain qualified nursing personnel in the country. Nevertheless, international outflow from China may be very visible but still represents only relatively small numerical loss compared with internal flows of nurses leaving nursing practice for other sources of employment (Fang 2007). Lacking strong research evidence to understand why nurses leave nursing practice, and how this issues influence patients and nurses outcomes in Chinese health care system, constitutes a barrier for Chinese nurses to effectively communicate their concerns to the hospital managers and policy makers.

6. The explanations of nurses' turnover worldwide

The majority of research contributing to nurse turnover uses the intention of leaving to predict actual turnover, which mainly focuses on nurses who are still employed in

the profession (Hayes *et al* 2006). There are many turnover predictors including different sources of dissatisfaction, unmet expectations, organizational environment factors and other sensitive issues. Multivariable measurements have been developed from economic, psychological and sociological perspectives (Table 5). These studies focus on matching or testing different theoretical models by quantitative research design, but even the most extensive turnover predictive models have underestimated some important antecedents (Maertz and Griffeth 2004). The discrepancy between intention and the actual behaviour of leaving and the validity and reliability of studies needs further exploration in different social-cultural contexts (Takase *et al* 2008).

The retrospective approach has an advantage since the whole leaving process can be examined in a relatively holistic way (Morrell *et al* 2008). A few studies focus on individuals who have left nursing (Duffield *et al* 2004a,b). However, self-reported accounts fail to explicate the motivation behind individuals' unique circumstances and linking them with decision processes still challenges a full understanding of turnover (Maertz and Campion 2004).

It is noteworthy to mention that an in-depth critique of the literature review prior to data collection and analysis should not be conducted since this may provide a priori assumption or framework, which includes categories that are inappropriate or incomplete when using a Grounded Theory approach (Glaser and Strauss 1967). The original overview of studies contributing to nurse turnover which is presented in Table 5 was revised in the second stage of the literature review following an initial analysis of the data. In the analysis of the data, the previous literature was not only treated as secondary data for verification of the emerged categories through the continuing process of constant comparative data analysis, but also expanded into wider and more focused literature by adding the data conceptualized categories as new key words in the second stage of the literature review.

Table 5 An overview of studies contributing to nurse turnover

Different research approaches	The factors or theoretical explanations of nursing turnover	Main results and limitation	Key studies
Predictive approach: using the intention of leaving to predicate actual turnover	<p>1. Models of Job satisfaction</p> <p>To examine the relationship between the job dissatisfaction and the intention to leave</p> <p>Sources of dissatisfaction</p> <ul style="list-style-type: none"> • Inadequate pay • Inadequate resources and staffing • Heavy workload • Stress • Burnout • Work relationships • Lack of flexibility in working pattern • Work-family conflict • Lack of opportunities for personal and professional development • Low morale among nurses • Lack of professional and organizational commitment • Concerns about poor standard of care 	<ol style="list-style-type: none"> 1. The strongest relationship with job satisfaction was found to be related to work content and environment. 2. Level of education achieved and pay were found to be inconsistent with job satisfaction. 3. Organizational factors are more influential than individual factors. 4. The relationship between the degree of satisfaction and turnover intention is inconsistent in the cross-culture comparative studies. 	<p>Irvine and Evans 1995</p> <p>Price 2001</p> <p>Aiken <i>et al</i> 2001</p> <p>Tzeng 2002</p> <p>Coomber and Barriball 2007</p> <p>Takase <i>et al</i> 2006</p> <p>Lu <i>et al</i> 2007</p>
	<p>2. Unmet expectations hypothesis</p> <p>The hypothesis uses pre-entry expectations acting as standards of comparison, and suggests that confirmation of employee's pre-employment expectations about the nature of their jobs leads to higher level of job satisfaction and organizational commitment and reduces likelihood of turnover.</p>	<ol style="list-style-type: none"> 1. The discrepancy between expectations and experiences is regarded as important predictor of nursing turnover, which is mainly based on findings from the psychological literature. 2. The findings provided only modest support for the hypothesis. 3. Many researchers concerned the direct met expectations measure might not have contributed significantly to the prediction of job satisfaction and turnover intentions. 4. Some researchers found that the post-entry experiences (were not simply met or unmet to pre-entry expectations. The passage of time may result in changes of professionals' expectations. 	<p>Lait and Wallance 2002</p> <p>Taris and Feij 2006</p> <p>Irving and Montes 2009</p>

	3. Person-environment fit theory The theory emphasises that it is the maladjustment/misfit relationship between the persons and their environment affects employees' work behaviour, and suggests how the degree of fit between them affects employees' occupational behaviour.	<ol style="list-style-type: none"> 1. Negative environmental characteristics contribute to nursing turnover. 2. The theory maybe cannot predict certain dimensions of a nurse-work relationship. 3. Nurses' perceptions of work values, the role of nurses, workplace environment, and organizational commitment have different effects on their intention to leave in different countries 	Mitchell <i>et al</i> 2001 Takase <i>et al</i> 2008
	4. Multivariables measurement Multivariate content models which developed from economic, psychological and sociological perspectives have focused on identifying turnover antecedents to address why employees quit.	Study results are often inconsistent with each other due to the complexity of defining and measuring multifaceted predictors, outcome constructs and differences among work contexts.	Mueller and Price 1990 Soothhill <i>et al</i> 1992
	5. Some sensitive issues <ul style="list-style-type: none"> • Nurses' perception of hospital ethical climate • interrelationship and intra-relationship with co-workers and managers • bullying in workplace 	These studies focus on testing different theoretical models by quantitative research design, but the validity and reliability of studies related to certain sensitive issues need further exploration.	Stevens <i>et al</i> 2002 Duffy <i>et al</i> 2002 Rosenstein <i>et al</i> 2002 Kleinman 2004 Hart 2005 Duddle and Boughton 2007 Yildirim and Aycan 2007
Retrospective account of voluntary turnover which focus on studying the actual leavers	1. Surveys by questionnaires To determine how the factors which influence nurses leaving the profession and influence tenure in profession	<ol style="list-style-type: none"> 1. A few studies found that the reasons why nurses entered or left the profession were varied and complex, and suggested that the reasons for becoming a nurse should be considered in association with the reasons why nurses leave the profession. 2. The reasons for leaving provided by actual leavers via questionnaires were superficial, since there was little opportunity for nurses to explain the reasons in their own words. 3. Exit interviews were suggested. 	Duffied <i>et al</i> 2004 Crow and Hartman 2005

	<p>2. The unfolding model</p> <p>The model focuses on how people quit as a decision making process and specifies that people quit in five paths</p>	<p>Using self-report questionnaires as retrospective accounts of the leaving decision making process has limitation. It needs further concerns that the individuals' account change over time due to complex interaction in a wider socio-political background.</p>	<p>Lee <i>et al</i> 2004</p> <p>Morrell <i>et al</i> 2008</p>
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For example; the “unmet expectation hypothesis” was not included as relevant literature in the first stage of the literature review. When “Mismatched Expectations” emerged as one of the core categories and was added as a new key word in searching for the more focused literature, the “unmet expectation hypothesis” was found to have a certain level of power in explaining turnover, although it has not yet been discussed in nursing studies. The expanded literature further provides validation and verification of the data grounded conceptual categories and theoretical understanding. (For more detail see the discussion chapter).

7. The limitations of ‘nurse turnover’ literature in the Chinese context

The shortage of nurses is more critical today than ever before worldwide (Duffield and O’Brien-Pallas 2002, Kovner *et al* 2007, WHO 2011). There is no indication that this will ease in the short term and previous solutions used will be successful (Aiken and Cheung 2008). There are some limitations of ‘nurse turnover’ literature in understanding nursing shortage issues, which particularly lack of evidence from the perspective of the Chinese nursing workforce in a Chinese context.

The first limitation is the definition of “nurse turnover” which has been used to link with nursing shortage. Redfern (1978:239) defines: “Wastage is a measure of loss from the manpower system whereas labour turnover looks at the system as a whole, both losses and additions”. Although the different definitions of turnover were not always clarified in previous studies, the term ‘nurse turnover’ has been used globally to understand the nursing mobility based on the western reality (Hayes *et al* 2006,

Coomber and Barriball 2007). In a review paper, Dovlo 2005 reports that an inability to realize the full potential of their available workforces has caused internal wastage in Africa countries, and advocates the development of indicators for monitoring and managing the wastage of health workforce in Africa countries. However, the phenomena of wastage has not been fully identified and explored in previous literature as an important issue related to the nursing shortage in different countries. The mainstream literature on nursing turnover struggles to find effective solutions of shortage, while meeting the number target of registered nurses tends to be the main concern from the perspectives of the nursing educational, and clinical institutions and the governments.

As this literature indicates, Chinese nurses who voluntarily leave nursing practice in China face different challenges to those of their western counterparts, due to the realities of the nursing employment environment from recruitment to final exit in the Chinese healthcare system and alternative work opportunities in the Chinese labour market. Therefore, the meaning and process of ‘nurse turnover’ may not simply match the reality as it occurs in China. My study focused on nurses leaving nursing practice, rather than look at nurses leaving the organization or profession. The reason for this was that, not only it was easier to clarify the participant under the personnel management in Chinese health care system, but that I was more concerned with the loss of bedside clinical nurses within the Chinese health system as a whole rather than the loss to the hospitals. Therefore, my study defines ‘nurses leave nursing practice’ as a sensitive concept in the beginning rather than simply impose the operational definition of “nursing turnover”. The definition also enables the study to include the leavers who have left the hospitals and those who are still working in the hospital but do non-nursing jobs, in which some positions may be already classified as particular nursing professional jobs in western countries, but may be regarded as non-nursing jobs by Chinese hospital managers.

Secondly, the overview of literature on nursing turnover has indicated the methodological limitations, as they mainly used questionnaires to carry out the

survey studies. The pre-existing findings from western knowledge might provide valuable experience for Chinese nurses to conduct a comparative study. Many Chinese nursing researchers frequently adopted the concepts of “job satisfaction, organizational and professional commitment, turnover, intention to leave” as standard measurements used to understand nursing turnover in China (Sun *et al* 2001, Liu *et al* 2002, Lu *et al* 2007). These studies try to produce generalizable and useful national or global data. However, by following what previous researchers have clarified as concepts based on Western realities, the common limitations of the quantitative survey or comparative studies are that there was little opportunity for Chinese nurses to explain their work and life with relevance to their intention of leaving in their own words. Therefore, researchers could not adequately establish a causal connection between the variables and failed to get the meaningful subjective experiences and perspective of the Chinese nurses’ leaving. Since there are many differences in cultures, social systems, health policies and nursing education between the West and China, the conceptions and indicators, which were provided by the multi-causal questionnaires based on Western literature, lacked significance and meaning within a context relevant for Chinese nurses.

Thirdly, the overall turnover literature presumes that the policy makers and hospital managers have a common awareness that retention of staff is an important issue based on the situation of nursing shortage and that they imperatively wish to manage turnover effectively (Hayes *et al* 2006). It is understandable that the researchers directly focus on giving suggestions for managerial intervention which may effectively deter leaving. Nevertheless, there is no sound evidence to prove whether the policy makers and hospital managers among the developing countries have a similar awareness or the motivation to retain qualified nurses as some western countries assumed, based on their social-economic-political situation (Dovlo 2005, Gill 2009), which should be a particular concern in China (Fang 2007, Xu 2003). In order to initiate effective nursing retention strategies, there is an urgent need for Chinese nursing research to produce data which is grounded in the Chinese context and helps the policy makers and hospital managers fully understand the phenomenon of nurses leaving nursing practice.

8. Conclusion

The critical literature review found that the reasons for the shortage of nurses between Mainland China and the West may differ. Compared with the great efforts to recruit and retain the nursing workforce in most industrialized countries, Chinese nurses face unique historical, political, cultural and educational difficulties in trying to resolve the problem of the nursing shortage by retaining nurses. The literature review on nursing turnover shows that multivariable indicators of turnover were increasingly added to explain the reasons for nurses' intention to leave, which includes nearly every detailed aspect of nursing work, environment and personal, professional and organizational characteristics. These descriptive findings might easily be understood by nurses based on their daily life, but the findings among the large studies might confuse the politicians in determining the priority for an effective intervention for retention without a comprehensive understanding. The available mainstream studies of nursing turnover in developed countries, and the limited studies about immigration in developing countries, had little to contribute to our understanding of the nursing mobility and shortage in Mainland China. The gap highlights the need to understand why Chinese nurses leave nursing practice and how this issue impacts on Chinese health care. The study seeks a theoretical explanation for their quitting, which can provide a comprehensively informed basis for policy and, hopefully, initial nursing retention strategies to improve the quality of Chinese health care.

Chapter 2 Research design

1. Introduction

Research design reflects a choice of decision about the priority being given during the entire process of research. It provides a theoretical framework for data collection and analysis (Bryman 2004, Silverman 2010). This chapter discusses the methodological approach taken in this research and its relative implications. It starts with reflection on the formulation of the research aim and research questions and then goes on to justify a qualitative study based on the theoretical perspective of symbolic interactionism. The most utilised method in the whole research procedure draws from the works of Glaser and Strauss (Glaser and Strauss 1967, Glaser 1978), especially the constant comparative method of analysis and the flexibility that the grounded theory approach allows. In-depth interview with the nurses who left clinical care is justified as the most effective method to collect data. The procedure of finding the interview participants was guided by the principle of theoretical sampling. Based on the pragmatic tradition in symbolic interactionism, the research design is open to being revised by its application in the field.

2. Formulation of the research aim and questions

The mainstream literature from Western countries maintains the assumption that the reasons for the growing shortage of nurses and the turnover in nursing staff seem to be similar everywhere (Tierney 2003). Therefore, there is an implicit suggestion that the pre-existing findings from Western knowledge might provide valuable experience to explain the reason for nursing turnover in the Chinese situation. It is a popular view among academics that the investigation of causes requires quantitative evidence and that only statistical analysis can be sufficiently rigorous for good research (Maxwell 2004), which is particularly true in Chinese nursing research following a medical science direction (Ding 2007). Based on this concern, originally I felt that it might be possible to design questionnaires from the Western literature

and carry out a survey study in order to explain “*Why do nurses leave nursing practice in Mainland China?*”

Through looking for the causal relationship, co-relationship and difference by quantitative studies, the deductive research strategy is suggested as being particularly appropriate in answering a “why” research question (Blaikie 2000). The ontological and epistemological assumption of the deductive strategy is based on critical rationalism (Popper 1972). Critical rationalism shares some aspects of positivism’s ontological assumption that reality exists outside the mind, however it insists that reality cannot be observed directly. All that can be done is to try to match theory with data (Blaikie 2000). This means that collecting any kind of useful data involves the use of theoretical ideas to provide direction for the data gathering, then the elimination of false theories or the revision of theories by showing that data does not fit with them. The fittest theories will survive (Blaikie 2000, Bryman 2004). However, as the literature chapter has demonstrated, the indicators, conceptions and theoretical models, which were provided by the multi-causal questionnaires based on the Western literature on nursing turnover and nursing shortages, lack consistent and significant meaning within the context of Chinese nurses.

It is also believed that social phenomena can be better understood when they are compared in relation to two or more meaningfully contrasting cases or situations. Therefore, a cross-culture comparative study based on a quantitative research design might seek explanations for similarities and differences in different national contexts by using one or more identical methods or research instruments (Bryman 2004). However, it still emphasises the descriptive and aspires to account for facts or variances based on positivist epistemology (Durkheim 1938, Bechhofer and Paterson 2000). A comparative study design assumes that human action is determined by external forces, which not only neglects the role of human consciousness, memories, goals, and values (de Vaus 2000), but also ignores many differences that are underpinned by the diversity of cultures, social systems, health policy and nursing education between the West and China. Therefore, one must question whether a

quantitative study, which is based on the available mainstream studies of nursing turnover and shortage in the developed countries, can capture the meaningful subjective experiences from the Chinese nurses' perspective and whether it could adequately establish causal explanations.

As May (1997) illustrates, how a research problem is defined depends on several factors, including culture, history and social power, all of which influence the values of social research. Weber (1947) believes that values not only could, but should play a role in research. From this perspective, I agree with Hammersley and Atkinson (1995) that social research always has a political element since it is not free from the influence of value. In order to develop the practical implications of my research, political understanding is as important as academic pursuits.

As the background of the study introduced, Chinese nurses continue to voluntarily leave nursing practice but at the same time keep quiet about their reasons for doing so, and the high rate of nurses leaving nursing practice has not attracted attention in Chinese society (Ye *et al* 2006). The thorough Chinese research literature in nursing turnover (Jiang 1997, Mao and Wang 2006, Luo *et al* 2007) demonstrates that their findings are closer to the beliefs of the researchers than to those embedded in reality and fail to establish causal connection between variables and consequences. Little is known about the leavers' experience during the stages of their entering, practising and leaving nursing practice in Mainland China. Chinese nurses have already been subjected to what Brieschke (1992) calls the technocratic and bureaucratic dehumanisation tendencies of objective studies based on the positivist epistemology under deductive research strategies. As a historically oppressed group, Chinese nurses have not been encouraged to express their opinions or intentions with support from nursing professional bodies or unions (Chan and Wong 1999). The lack of any strong research evidence constitutes a barrier for Chinese nurses to communicate effectively and conduct a dialogue with society about nursing workforce problems (Pang *et al* 2000). Any effective intervention to initially retain a stable nursing

workforce is difficult without a comprehensive understanding of why nurses voluntarily leave nursing practice in Mainland China.

I have considered whether a larger-scale survey could be used as a triangulation strategy to improve my research design. However, there are several reasons for me to reject this form of survey design and which led me to mainly focus on the in-depth interview with the leavers. First, as explained in the literature chapter, the main stream literature on turnover follows the prospective approach, which mainly uses previously defined variables, multi-causal questionnaires and focuses on stayers, and has not captured the meaningful subjective experiences nor fully understood the causal process of nurses leaving clinical care. Secondly, it was found that although some researchers have reduced the methodological limitation in comparison to the majority of nursing studies in China, with sound statistical technique (Lu et al 2007). Nonetheless this study could not effectively discuss the deep rooted causes of the high levels of intention to leave by studying nurses' job satisfaction and related factors. Thirdly, strenuous attempts were made to obtain the official nursing staffing statistics data in the hospitals in the initial stages of developing this study, but I found that the staffing data lacked reliability. The reliability of any statistical information obtained through the hospitals might then be called in to question, which was confirmed recently by a Health of Ministry Department announcement (MHPRC 2010b).

Mackay (1989) suggests that what nurses have to say can serve as a useful barometer by which to measure the state of a health service as a whole. I wholeheartedly agree with Lather (1991) that the task of social researchers is to remove the barriers that prevent people from speaking for themselves. The Chinese nurses who have voluntarily left nursing practice have rich experiences and are in the best position to express their views freely, without too many constraints caused by the sensitive power relationships which exist within the health system. Thus, it is imperative to listen to what the leavers have to say about their experiences during their nursing career decision-making process and their own accounts of their voluntarily leaving

nursing practice. Therefore I propose the aim of my study which should be: **To understand why nurses leave nursing practice by exploring their career decision process from entering to exiting nursing practice in Mainland China.**

According to the suggestion of Silverman (2010), an initial move should be to give close attention to how participants locally produce contexts for their interaction, so that from the question of “how” we can then fruitfully move on to “why” questions about institutional and cultural constraints. Therefore, the research questions will focus on:

- **How do leavers describe their experiences of being a clinical nurse during their entering, practising and leaving nursing practice?**
- **How do they explain their reasons for their leaving nursing practice in Mainland China?**

The formulation of my research aim and research questions has helped me to clarify the subjectivity involved in my study. As Reinharz (1997) declares, if the researcher holds several positions, each aspect is never free from the influence of others. I thought about my positioning and responsibilities as a nurse and a leaver, a nursing teacher, a student, or a social science researcher by carefully examining my personal details (Appendix 1).

Firstly, I worked in a provincial teaching hospital as a Chinese registered nurse for ten years and received 13 years of different levels of nursing education, from diploma to doctorate level. According to the debate about “insiders” and “outsiders” (Coffey and Atkinson 1996, Naples 1997), my knowledge of nursing has underpinned my research credibility as an “insider”. There are obviously advantages for me in understanding at first hand the particular demands, rewards and dilemmas related to nursing and their interaction in the clinical setting and in wider society.

Secondly, I left clinical care eight years ago and am now a nursing teacher at a Chinese University. I have a very close personal and professional relationship with my previous nursing classmates, colleagues, nursing students and nursing scholars. It

is undeniable that I am enthusiastic about helping nurses as I feel this is my responsibility. I avoided interviewing the leavers whom I already knew very well because of our close work relationship in order to reduce the risk of using a convenience sample. I took different approaches to recruit and select participants follow the principle of theoretical sampling. Meanwhile I wrote a memoir of my own case as one of the 'leavers' before starting the fieldwork but put it away until the core categories and theoretical explanation model emerged clearly from primary data from the accounts of participants. I then started to use my personal case as secondary data as a way of checking validity and verification of the findings by closely examining whether and how the findings fit or work on my personal account by constant comparative analysis.

Thirdly, with a further degree in medicine in China, I had my research training from different disciplines as a postgraduate student in UK. All of this experience provided me with the chance to rethink the situation about Chinese nursing from a certain social distance. Therefore, to some degree, I also act as an "outsider" (Naples 1997), which means that I am less likely to take for granted the accepted working practices and attitudes. The advantage of social distance may elicit explanations, which are assumed to be known by someone with an insider status (Miller and Glassner 2004).

I asked myself the following questions: *"Do I take responsibility for a particular role in interpreting the finding of my research? Is the aim of my study for the benefit of my clinical colleagues, or for the development of nursing education? Does the study provide a potential challenge to the government as a critical academic, or does it add understanding of nurse's leaving and the nursing shortage in relation to a social problem?"* I feel that these representations are not mutually exclusive. I could not straightforwardly answer that the study should side with those who are being studied as Becker (1967) declares. As a PhD student, empathy for the participants may be questioned as being incompatible with good academic work. However, reflexivity has heightened the awareness of my own subjectivity by illustrating how my positions and roles have influenced the act of presenting my work to the audience.

It was further supported by Maso's (2003) argument that subjectivity is necessary in order to facilitate the researcher in pursuit of answering "true" questions. He reminds us to think about the well-known fact in the history of science that, while researchers were motivated by the true meaning of the questions and value of research, they usually employ all the power of their mind in choosing the path that would lead them to true knowledge with passion (Westfall 1993, Maso 2003).

By being reflective about the participants' social words as well as my own, and being able to listen and understand, my enthusiasm and empathy for the nurses avoided compromising the commitment to the value of sociology (Mill 1978). As Finch (1984) argues, recognizing the intrinsically political nature of both theory and data means that the sociologist has a great responsibility to be open and scholarly about the procedures and conclusions of research. I agree with the view of Finlay and Gough (2003) that the subjectivity in research can be transformed from a problem into an opportunity through reflexivity and I have applied reflexivity at all stages in my study.

3. A qualitative study

The subjective viewpoint in social science is highlighted by Weber, who views sociology as:

*...a science which attempts the interpretive understanding of social action in order thereby to arrive at a causal explanation of its course and effects
(Weber 1947:88)*

Weber attempts to incorporate both causal explanations and interpretive understanding. Rather than by attempting to correlate previously defined variables by a quantitative study, Maxwell (2004) advocates using qualitative research as a method of understanding and offering causal explanation, which should be based on individual interpretation and explanation by focusing on the causal process of the specific events and circumstances. In order to understand why nurses voluntarily leave nursing practice, my study focuses on exploring nurses' career process from

recruitment to final exit and interpreting their experiences and perceptions of exiting clinical nursing from the leavers' perspective. Blaikie elaborates the meaning of understanding:

The focus is not so much on the explanations that the researcher constructs but on the explanations social actors can offer and which can be used by the social researcher to construct a social account of their activity (Blaikie 2000:77)

Understanding is more concerned with reasons or accounts social actors give for their action rather than being concerned with casual explanations by deductive arguments.

Bryman (2004) further suggests that a qualitative research design is appropriate when the purpose of study is to gain an understanding of the subjective experiences of the participants, which helps the investigators to discover and understand through knowledge of the lived individual experiences (Weber 1947). As Melia (1987) advocates, a qualitative study can capture plausible stories in investigating nursing practice, as it prompts and probes both the declared and the implicit or tacit routines and rules which a nurse may use. Furthermore, qualitative research allows researchers to get close to the data and to provide opportunities for them to derive their concepts from the data that are gathered (Glaser and Strauss 1967).

An inductive strategy of linking data and theory is typically associated with qualitative research (Silverman 2010, Bryman 2004). It moves from specific instances to more abstract generalizations extending from the synthesis of data and eventually results in the identification of concepts and theory development (Glaser and Strauss 1967). A qualitative study assists with the definition of the concepts relating to the experience of the participants (Bryman 2004), and determines how people really behave and what people actually mean when they describe their experiences and make decisions about their actions (Silverman 2010). Qualitative research acknowledges the differences between people and other natural elements and requires the researcher to interpret the subjective meaning of social action;

therefore strong emphasis is placed on the researcher as an element of the research process (Bryman 2004).

The purpose of a qualitative study is to provide an understanding of reality and to make sense of it (Bryman 2004). Denzin (1978) argues that research methods are of little use until they are seen in the light of the theoretical perspective and sound research strategies. Creswell (2007) indicate that different epistemology portrays different ways of understanding the social world. Epistemologies provide philosophical grounding to decide what kinds of knowledge are possible and ensure credible, adequate and believable results (Lincoln and Guba 1985, Denzin and Lincoln 2005, Silverman 2010). The rationale for using a qualitative research design in this study is based on the symbolic interactionism theoretical orientation.

4. Theoretical perspective of symbolic interactionism

The foundation of symbolic interactionism was laid by Mead (1934), whose work was based on pragmatic social psychology (Barbalet 2009). The term “symbolic interactionism” was first presented by his best known student, Blumer (1937). Although contemporary symbolic interactionism comprehends several diverse schools of thought, all of these orientations share the substantive view that human beings construct their realities in a process of interaction with other human beings (Meltzer, Petras and Reynolds 1975). From the perspective of symbolic interactionists, every human being defines the world differently. Denzin suggests.

If sociologists are to accurately explain these different definitions and relate them to action, they must penetrate this subjective world of concepts, experiences and reactions. (Denzin 1978:215)

Blumer (1969) advances symbolic interactionism based on three basic premises, which underpin the methodological choice for this study.

The first premise is that, “Human beings act toward things on the basis of the meanings that the things have for them.” (Blumer 1969:2) It emphasises that the

meanings things have for human beings are central in their own right. The methodological implications of the premise raise a serious question about the validity of the most predominant approach in psychological and social science, which tends to treat human behaviour as the product of various factors in the study of the human group life and human conduct. As a result, meanings disappear by being merged into the initiating or causative factors, or meaning can be ignored as a mere neutral link between the factors and the behaviours (Blumer 1969). Blumer suggests,

Human beings are seen as living in a world of meaningful objects, therefore if the scholar wishes to understand the action of people it is necessary for him to get inside their worlds of meaning and see their objects as they see them (Blumer 1969:2)

The second premise is that, “the meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows” (Blumer 1969:2). It refers to the source of meaning as social products arising in the process of social interaction between people. As Blumer (1969) argues, the premise gives symbolic interactionism a very distinctive position from two dominant views: one reflects the traditional position of realism which lodges meaning in the objective makeup of the thing that has meaning; the other regards meaning as an expression of psychological elements in the person. They view the use of meaning by the human being in his action as being no more than an arousing of, and application of, already established meaning (Blumer 1969). The methodological consideration based on the second premise is that the definition of the interaction is not achieved when the study itself presupposes a special form of interaction; therefore a different investigating procedure is required by seeing that human interaction is a process of the formation of meaning in play (Blumer 1969). Meanwhile the methodological consideration from symbolic interactionism also demands that the processes or consequences that a person goes through as they move from one stage to another must be covered and the explanation of each step is part of the explanation of the resulting behaviour (Denzin 1978). Denzin (1978:11) reminds “what may operate as a cause at one step in the sequence may be of negligible importance at another step”. These ideas of symbolic interactionism further support that all causes of nurses’ leaving nursing practice do not operate at the same time and we need to take into account the fact that patterns of behaviour develop in sequences. Therefore, it is necessary to explore each step of the

nursing career decision-making process which they go through when entering, practising and exiting nursing practice in China, before an investigation is regarded as sufficiently complete to help to fully understand why a nurse becomes a leaver.

The third premise is that, “these meanings are handled in, or modified through, an interpretative process used by the person in dealing with the things he encounters.”(Blumer 1969:2) The premise further differentiates symbolic interactionism in that the use of meaning by the actors occurs through a process of interpretation. Symbolic interactionism concerns the constructive capacity of individuals through interpretive processes, and does not presume an individual will make a rational choice in pursuit of their own self-interest, which draws a clear contrast to the Rational Choice Theory (Barbalet 2009). Based on this theoretical perspective, it therefore becomes essential to gather statements made by participants with a view to examining the various dimensions of the situation that they construct (Blumer 1969, Denzin 1978). It is necessary to see that meaning plays a part in action through a process of self-interaction, which includes an internalized social process in that the actor is interacting with her/himself. By virtue of this process of communicating with her/himself, interpretation becomes a matter of handling meaning (Blumer 1969). Meanwhile, as Denzin (1978) suggests, the act of engaging in social research also must be seen as a process of on-going patterns of interaction between the researcher and the researched. Therefore, the research not only interprets the natural world where the leavers inevitably interacted with each other and other surrounding elements during their career decision-making process, but also involves interpretation of the interaction between researcher and research participants concerning how to understand the meaning of each other’s actions, such as body language, expression, tone of voice, gesture, which occur in the process of research during data collection and analysis. Symbolic interactionists believe that vocal gesture and behaviour provide the basis for symbolic interaction, which links individuals within the society (Meltzer *et al* 1975). Language is regarded as the principal vehicle for social communication by Mead (1934). I agree with Blumer’s (1969) ideal that talk and interaction are more real and more deserving of attention.

These key premises of symbolic interactionism provide an interpretative view of sociology which puts emphasis in understanding the actions of participants on their active experience of the world and the ways in which their actions arise from and reflect back their experience (Blumer 1969, Denzin 1978). As the basic theoretical framework of my study, symbolic interactionism proposes and supports a qualitative study as the best way to gain a deeper understanding of nurses leaving nursing practice in China by addressing the reality fully and effectively.

5. Drawing upon a grounded theory approach

5.1 Rationale of drawing on a grounded theory approach

Blumer (1969) proposes the methodological position for symbolic interactionism rather than emphasising its theoretical perspective. However, there is a common criticism when symbolic interactionism is regarded solely as a research methodology:

Symbolic interactionism has largely failed to set down systematically what it considers the proper and precise procedures of verification to be utilized in researching the framework (Meltzer, Petras and Reynolds 1975:118).

Baker *et al* (1992) suggest that the credibility of existing qualitative methods will only be established if researchers explicitly and consistently describe their data collection and analysis procedures within the underlying assumptions of the approach they select.

Grounded theory, ethnography and phenomenology are the three main qualitative approaches with systematic research procedures in studying human experiences (Parahoo 1997, Creswell 2007). Ethnography is a methodology in which the researcher seeks to understand the shared and learned patterns of values, behaviours, beliefs, and language of a culture-sharing group (Hammersley and Atkinson 1995). As the study of culture, the essential of ethnography is seeking to learn from people and to be taught by them (Hammersley and Atkinson 1995), which is compatible with the scope of my study purpose. Ethnography usually involves spending

prolonged time in the field and more often tends to be carried out through participant observation in which the researcher is immersed in the day-to-day lives of people (Cresswell 2007). As Creswell (2007) argues, what distinguishes ethnography from other qualitative studies is the cultural perspective, not the research technique. The aim of my study mainly focuses on the leavers' retrospective experiences and their accounts of the leaving process. It is unnecessary to doctrinally use participant observation. Phenomenological research focuses on individuals' interpretations of their experience and the ways in which they express them (Husserl 1969), but it does not particularly seek to understand and explain the general process of nurses leaving nursing practice by focusing on the different stages of their career decision-making. Grounded theory can catch the developing, on-going social process with many stages, and it seeks to generate theory which is grounded and systematically derived from data by exploring the experience of individuals, particularly in the actions, interactions and processes of the people involved (Glaser and Strauss 1967). It is regarded as the most suitable methodology to use to understand psychological and social processes by collecting qualitative data (Glaser 1978).

However, there are some conflicting and unresolved debates regarding grounded theory in the process of theory generation with different emphases on induction, deduction and verification (Melia 1996, Heath and Cowley 2004). It is important to be aware of the challenges and strengths of using the grounded theory approach in the study by clarifying the theoretical debate of grounded theory and the range of its implications.

5.2 Theoretical debates on grounded theory and implications

Grounded theory was first developed in sociology by Glaser and Strauss (1967). Its roots lie in symbolic interactionism, which itself stems from the pragmatist ideas of James, Dewey, Cooley and Mead (Hammersley 1989, Barbalet 2009). The interactionist approach, together with naturalistic inquiry, which was developed by Blumer (1969), is the key influence on grounded theory. Grounded theory combines the depth and richness of the qualitative tradition with the logic, rigour and

systematic analysis inherent in quantitative research (Glaser and Strauss 1967, Glaser 1978). Thus it enables the researcher to generate systematically a substantive theory grounded in empirical data (Glaser and Strauss 1967). However, the two founders of grounded theory jointly started out with Glaser's positivism and Strauss' symbolic interactionism (Stern 1994), but ultimately disagreed about the data analysis and theory generating procedure due to their different academic backgrounds (Glaser 1992). The original work (Glaser and Strauss 1967, Glaser 1978) is represented in various ways based on their followers who declare the different epistemological positions for their contribution (Glaser 1992, Strauss and Corbin 1990, Charmaz 2006)

By a close study of the literature on the grounded theory development, I agree with Hammersley's (1989) argument, that the methodological significant difference of grounded theory might be overstated, because the theoretical perspective of symbolic interactionism is relevant to the divergent grounded theory. Indeed, as Hammersley (1989) points out, if meaning is conferred on the social world by the interaction of actors, can there be a reality of basic social process to be investigated? Hammersley (1989:135) further claims that the paradox is easily resolved: "once we accept that there can be multiple non-contradictory descriptive and explanatory claims about any phenomenon". Heath and Cowley (2004) support the view that a shared theoretical understanding of the reality can be assumed in the base of symbolic interactionism, although there may be slight epistemological differences of grounded theory. Therefore, rather than debate the relative merit of the different epistemological perspectives of the development of grounded theory, the question that needs to be answered is what all this re-definition achieves and how re-positioning of grounded theory adds to the analysis of the data and the production of a theory.

Grounded theorists advocate that theories should be grounded in data from the field and must "fit" and "work" (Glaser 1978:3). As Silverman (2010) argues, the theory only becomes worthwhile when it is used to explain something. It is worth emphasising the original definition of "theory" made by Glaser and Strauss:

Theory in sociology is a strategy for handling data in research, providing models of conceptualisation for describing and explaining (Glaser and Strauss 1967:3)

From Melia's (1981) view, the importance of the constant comparative analysis lay in the explanatory power of the conceptual categories. Therefore when the link between these conceptual categories is made explicit, it offers a means of explanation (*Ibid*). Heath and Cowley further advocate:

It is wise to remember that the aim is not to discover the theory, but a theory that aids understanding and action in the area under investigation. (Heath and Cowley 2004)

Based on their personal experience of developing as grounded theorists, Heath and Cowley confirm the importance lies in that the researchers need to select the method that best suits their cognitive style and develop analytic skills through doing research (*Ibid*). In order to fulfil the aim of this study, I draw upon the work of Glaser and Strauss (1967) and Glaser (1978), especially the constant comparative method of analysis, and the flexibility that the grounded theory approach allows to strengthen the systematic research procedures.

5.3 Strength of constant comparative method

The constant comparative method as a strategy of handling qualitative data is particularly emphasised in *Discovery of Grounded Theory* (Glaser and Strauss 1967). By the constant comparative method, grounded theory moves beyond description and seeks to generate a theory which is grounded in data by exploring an individual's experiences (Glaser and Strauss 1967). The method enables the generation of theory through systematic and explicit coding and analytic procedures (Glaser 1978).

The difference between "analytic induction" and the constant comparative methods has been made clearly by the founders of grounded theory in their original contribution.

'Analytic induction' has been concerned with generating and providing an integrated limited, precise, universally applicable theory of causes

accounting for a specific behaviour. ...It tests a limited number of hypotheses with all available data, consisting of numbers of clearly defined and carefully selected cases of the phenomena. ...In contrast to analytic induction, the constant comparative methods is concerned with generating and plausibly suggesting many categories, properties and hypotheses about general problems, some of these properties may be cause, as in analytic induction, but unlike analytic induction others are conditions, consequences, dimensions, types, process, etc. (Glaser and Strauss 1967:103-104)

The constant comparative method is regarded by Glaser (1978:16) as: “A process composed of a set of double-back steps. As one moves forward, one constantly goes back to previous steps”, which distinguishes grounded theory from other qualitative studies. Glaser and Strauss (1967) mention that sociological research typically involves alternating between inductive and deductive logic as research proceeds, while they truly remain the original inductive commitment in their earlier work (Glaser and Strauss 1967, Glaser1978).

Maintaining the balance between the two logics and following their interplay is dictated by whether the research is initiated primarily as deductive (derived or preconceived) or as inductive. Grounded theory is, of course, inductive; a theory is induced or emerged after data collection starts. (Glaser1978:37).

Glaser (1978) further elaborates that deductive work in grounded theory is used to derive from induced codes conceptual guides as to where to go next for comparative data.

Deduction is in service of further induction and the source of derivations are the codes generated from comparing data, not deductions from pre-existing theories in the extant literature.... The focus of deduction is on more comparison for discovery, not on deriving a hypothesis for verification (though this may occur as a byproduct). (Glaser 1978:38)

Glaser (1992) criticises the deductive emphasis on Strauss and Corbin’ (1990) axial coding and conditional matrix, which requires the asking of numerous questions and speculation about what might be rather than what exists in the data (Glaser 1992). Melia (1996:376) gives a vivid comment on it “the technical tail is beginning to wag the theoretical dog”, which was echoed by Health and Cowley (2004), who doubted that the technique might move down irrelevant paths and close off an effective research investigation.

Glaser (1978) suggests that the best way to produce theory is to think about one's own data to generate ideas by the simplicity of the central idea of the constant comparative method. He insists that the more natural emergence led to confidence in the relevance of theory. Glaser (1992) contends that if constant comparison is completed properly, the checks or verification of accuracy are carried out through the comparison itself. Charmaz (2006) emphasises that every qualitative researcher should take Glaser's warnings about forcing data into preconceived categories through the imposition of artificial questions by stressing a constant comparative approach. By an inductive strategy, grounded theory allows data collection without a preconceived framework (Glaser and Strauss 1967).

5.4 Flexibility of the grounded theory approach

A range of flexible strategies has to be taken by grounded theory to avoid preconceived concepts or theories during constant comparative analysis by balancing induction, deduction and verification.

Firstly, by adopting an inductive approach, grounded theory provides a very specific way to indicate "when", "how", and "in which purpose" (Glaser and Strauss 1967) to introduce the literature, the theory, the personal experience and any other naturally occurring data. Many qualitative and quantitative researchers do not think it is possible to suspend from making references to theory as the grounded theory approach allows. Glaser (1978) advocates that prior understanding should be based on the general problem area and reading very widely to alert or sensitize one to a wide range of possibilities, while an extensive review of literature should only start when a core category starts to emerge. At that point the close relevance of literature is recognized and more focused reading allows literature to be used as additional data by constant comparative analysis, whereby its powerful impact bends the merging theory from its true path (Glaser and Strauss 1967, Glaser 1978). As Glaser (1978) suggests, the researcher should fight preconception and learn not to know until the

core problems has merged and proves to be a stable focus of the research. Thus the researcher will not be forced or have preconceived ideas by pre-empting concepts and can focus firmly on his discovery (*Ibid*). While the theory seems sufficiently grounded and developed, the literature and theory related to the field must be reviewed through the intergradations of ideas (Glaser 1978). Like other researchers, grounded theory researchers have an obligation to discuss their work with the scientific community. Glaser (1978) suggests that the previous theories or concepts can be integrated into the emerging theory, but merely treated as secondary data by a constant comparative process. In his view, grounded theory does not confront other theories with being wrong or synthesize with other theories that seem right. However, literature is not for the verification of emerged theory or concepts, but can only enrich the discussion of research results by a continuing inductive analysis (Glaser 1978).

Secondly, grounded theory can use ‘sensitizing concepts’ in the inductive research strategy rather than accept ‘operative concepts’ by adopting deductive arguments. As a symbolic interactionist, Blumer (1969) argues that an adequate understanding of social life requires recognition of the fact that individuals and groups find their way by defining and interpreting the objects, events and situations that they encounter. Blumer (1969) suggests the use of sensitizing concepts with refining an initial flexible concept. Simply imposing an “operational definition” will fail to totally examine how such phenomena or activities come to have meaning in what people are actually doing in everyday naturally occurring situations. Sensitizing concepts provide clues and suggestions about what to look for. The notion of sensitivity in grounded theory refers to openness on the part of the researcher to different ideas, to a process of interrelating theoretical insights and data. Grounded theory goes beyond description and thus will enable the researcher to develop theories based on ‘reality’ as it exists (Glaser and Strauss 1967).

5.5 Limitation and solution of data collection

Researchers can use grounded theory techniques with varied forms of data collection. Theoretical sampling is a pivotal strategy in grounded theory. Glaser and Strauss define theoretical sampling as:

The process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges (Glaser and Strauss 1967:45).

Theoretical sampling means that the sampling of additional incidents, events, activities, populations and so on is directed by the evolving theoretical constructs (*Ibid*). When doing theoretical sampling, researchers must determine what data resources they should follow, such as groups of people, documents and bodies of literature (*Ibid*). Although Glaser (1978:8) states that it is necessary to treat “all as data” to generate good ideas, data gathering remains problematic and disputed in grounded theory (Glaser 1992, Strauss and Corbin 1990, Charmaz 2006). As Glaser warns (1992), every qualitative researcher should avoid forcing data into preconceived categories through the imposition of artificial questions. Although Charmaz (2006) agrees with what Glaser advocates, she is also concerned that data collecting using theoretical sampling does demand that researchers ask questions and follow hunches, if not in direct conversation with respondents, then in the notes or memos about what to look for next. Glaser (1992) assumes that data becomes transparent, because researchers will see the basic process in the field through respondents telling them what is significant. However, Charmaz (2006) doubts that what researchers see may be neither basic nor certain. Glaser (1992) also admits that actually generating theory at the moment of collecting data is never easy and usually it requires reflection afterwards. Blumer (1969) has already questioned whether researchers can suspend their awareness of relevant theories or concepts until a comparatively late stage in the process of analysis as advocates of grounded theory suggest. Health and Cowley (2004) point out that the novice researcher may be becoming more concerned with process questions rather than creative, interpretative questions and answers, therefore the substantive coding would be restricted by forced questioning and subsequent sampling, which could result in the researchers’ interests

and preconceptions shaping the research at the expense of problems of concern to participants (Ibid). When deduction and verification became the servants of emergence, it would be in danger of confirming existing knowledge rather than discovering new (Ibid).

Concerning the unresolved disputation of theoretical sampling procedures, and the practical difficulties involved in carrying out a genuine theoretical sampling with constant interplay of data collection and analysis (Bryman 2004), it is more important for me to focus on the research aim by following what the participants like to talk about and to wait for concepts to emerge by constant comparative analysis of incidents in old and new data, as Glaser (1978) suggests. I planned to get the fullest data collection from the group of leavers, but I did not assume that they would necessarily be representative of the whole leaver population. It is often sufficiently useful to seek plausible suggestions in approaching sampling according to the categories and incidents which emerge from data by a constant comparative analysis (Glaser and Strauss 1967). Therefore I would have to keep an open mind in accordance with the spirit of theoretical sampling during the data collection and analysis and must tolerate confusion and uncertainty during the fieldwork before the core category emerges from constant comparative analysis.

Although I prefer rigorous approaches with systematic procedures for inquiry, I totally agree with Mills' wise view:

We should be as accurate as we are able to be in our work upon the problems that concerns us. But no method... should be used to delimit the problems we take up, if for no other reason than that the most interesting and difficult issues of method usually begin where established techniques do not apply. (Mills 1959:72)

Based on the pragmatic tradition in symbolic interactionism, the heart of the sociological perspective is concerned with the meaning of social action from the perspective of the participants (Blumer 1967). The focus of all qualitative researchers needs to be on understanding the actual social worlds and the phenomenon being explored rather than solely on the readers, the researchers, or the

participants being studied (Bryman 2004, Creswell 2007). The actual carrying out of qualitative research should not be relegated to secondary status behind the philosophical ideas (Creswell 2007). Silverman (2010) also advocates that qualitative research should resist becoming overly attached to any single research technique. Schatzman and Strauss further support the pragmatic criterion of doing research in the field.

The field researcher is a methodological pragmatist. He sees any method of inquiry as a system of strategies and operations designed-at any time-for getting answer to certain questions about events which interest him
(Schatzman and Strauss 1973:7)

With a pragmatic criterion of usefulness in choosing different research strategies, I have carefully justified the rationale of the qualitative interview study by drawing together the constant comparative method from the grounded theory approach and the flexible process towards data collection following the spirit of theoretical sampling. In this way, I have taken with great seriousness the words and actions of the people studied, which aims to meet both non-academic and academic audiences as Glaser and Strauss (1967) advocate.

6. In-depth interview

In order to obtain meaningful, valid and reliable data, it is reasonable to ask leavers for retrospective accounts of the changes that have affected them since the research topic is grounded in their lives and they know best about their own experience and decision-making processes. As March (1978:601) argues, “Individuals typically are able to make sense of their actions only after they have been taken and their consequences became apparent.”

Arksey and Knight (1999) suggest that interviewing is a powerful way of helping people to articulate their tacit perceptions, feelings and understandings and make explicit things that have been implicit. Rubin and Rubin (1995) further supported the concept that our ability to speak and be understood depends on the existence of languages as a structured system of meaning. The interview offers an excellent

instance of how the interviewees' attitudes towards a social object represent a combination of their own attitudes and those of their social groups (Denzin 1978).

The study does not intend only to describe the Chinese nurses' leaving processes, but also wishes to understand the meanings that underpin their career decision making and provide a theoretical explanation of the events as they occur. The purpose of qualitative interviewing is to obtain rich data to build theories that describe a setting and explain a phenomenon holistically and comprehensively (Rubin and Rubin 1995). From Mead's (1934) view, the reality of past is in its interpretation of a present; while the interpretation of a present is to give an explanation of that present, which gives an account of how that present becomes continuous with a past. Blumer (1969) believes that the solution of any social problem cannot be justified without reconstructing the past and giving its new meaning within the present conflict.

Meanwhile the sort of emotions or sensitivities that might be raised by the research topic and appropriate strategies for dealing with them should be noted (Rubin and Rubin 1995). During the face to face in-depth interview, the researcher respects the interviewees' needs and feelings and develops a strong empathy with the interviewees, which will take on the more therapeutic role of listening and talking with them. However, by being reflective about the participants' social worlds as well as her own, I avoid reducing the qualitative research to an emotionalist interview (Silverman 2010).

It is important to examine wider sociological literature about emotions based on symbolic interactions, thus the researcher's enthusiasm and empathy for the nurses will avoid compromising the commitment to the values of sociology (Mills 1959). James (1897) nominates emotion as a core basis or source of selective interest and argues that feeling is the basis of rationality. A number of publications have provided a symbolic interactionist account of emotions, in which emotion remains an object of cognitive interpretation (Barbalet 2009). Although Hochschild (1983) argues that emotions are included in the subject or constructed through emotional work, Barbalet

(2009) criticize that “emotion work and feeling rules” reveals that Hochschild in fact demonstrates that feeling rules do not do what she claim for them. Barbalet (2009) argues that the subjectivity of emotion, of which we may not necessarily be aware, may affect the capacity of cognitions and be primarily responsible for social conduct and action. She further supports with overwhelming evidence that emotion not only plays a primary role in framing options for making choices but underlines rational thought (Barbalet2009). Therefore, attention should be paid to the significant role of emotion during my data collection and data analysis as a key element in symbolic interactionism orientation.

In-depth qualitative interview, as the term implies, seeks to achieve the same level of knowledge and understanding of the participants. Rubin and Rubin (1995) further suggest that qualitative interviews are especially useful when the research needs to bring some new light to puzzling questions, since it will assist the definition of the concepts relating to the experience of the participants. Qualitative interviews are a way of uncovering and exploring the meaning underpinning people’s lives, routines, behaviour and feelings, which focus on the participants’ understanding rather than checking the accuracy of the interviewers’ accounts (Rubin and Rubin 1995). With highly structured questions, the participants will answer only what is asked, often without elaboration. They may be reluctant to volunteer and so disturb the research process (Bryman 2004). Thus, many narrow questions may threaten the validity of the study. Therefore I should avoid any suggestion of forcing people to answer questions that may never arise in their day-to-day life, as Silverman (2010) suggests. A flexible, semi-structured interview will not restrict the responses but allow the participants to share their experiences that are meaningful or relevant to them in their own words (Bryman 2004). It allows the researcher to follow the responses produced (Rubin and Rubin 1995). When ideas and issues emerge, the flexible interview allows the researcher to focus on and verify specific points from earlier interviews (*Ibid*).

I discussed with supervisors, and planned to use, a semi-structured interview with 10 main questions (Appendix 2), which cover each major stage of nursing career decision-making processes following a chronology. It is important to ensure that each question accommodates the experiences and perspectives of individual conversational partners and matches the research design. The topic outline questions are normally specified, but allow people to answer more on their own terms and the interviewer is freer to probe than in standardised interview, facilitating an in-depth dialogue (May 1997). It emphasises flexibly structured questions and lays more focus on the participants' answers.

Therefore, although I have the question lists in mind, the interview is sufficiently flexible to be ordered in any way that seems natural to the respondent and to the interview situation (Schatzman and Strauss 1973). Actually, the question list has been adopted as the interview guideline during the research process. (More detail will be given and described in data collection)

The following section will start by giving a brief introduction to the process of doing research in the field from gaining access to the research site and participants and handling ethical problems as well as collecting and analysing data.

7. Doing research in the field

The idea of doing field research is a useful description of using various flexible qualitative research methods to carry out a natural sociological study based on the symbolic interactionists' perspective (Blumer 1969, Schatzman and Strauss 1973). Doing qualitative research is not merely the use of a set of uniform techniques but depends on a complex interaction between the research problem, the researcher and those who are researched (Silverman 2010).

The data collection began in July 2009 and finished at the end of March 2010. The focus here is the issues with which I have to cope actively in a variety of social situations, from different perspectives and the associated problems involved in order to ensure the trustworthy nature of the study throughout each step of the research processes.

7.1 Research site

The research site is located in Hangzhou. It is the capital city of Zhejiang province in the east of China with a population of 8.7 million (Hangzhou Statistics Bureau 2011), and is regarded by nurses as one of most attractive cities to work in, which means that the research setting is not an area where particular difficulties related to the shortage of nurses apply in China (Table 4). The terms and conditions of hospital employment for nurses in this city are not substantially different from elsewhere in China under the central government control. Although the samples are not representative of nurses throughout China, their account of nursing is not likely to differ greatly from those of other nurses working within the Chinese health care system.

7.2 Sampling

The best method for selecting good participants is to select those who are knowledgeable about the issues being researched and are willing to talk at length with the researcher (Morse 2000). Being sensitive to the hierarchy and organisational structure with the health authority, I did not choose to interview practicing nurses because of their reluctance to criticise the organization or their fear of jeopardizing their future job references. The selective sampling focuses on nurses who have voluntarily left clinical nursing care, which included nurses who are both staying in and leaving their employed hospitals.

Inclusion criteria: Participants must be registered nurses who have been working in clinical care and left their nursing practice in the last 5 years. Although Chinese nurses' on-going leaving has become visible in the past ten years, the retrospective

period needs to be shortened since the participants may remember their experience and feelings of their nursing career decision-making as insiders. Meanwhile, setting the leaving period at a maximum of 5 years allows participants enough time and space to make sense of their actions as an outsider looking back from their current position at their nursing career decision-making process when the consequences of their departure have become apparent. The participants include leavers with different years of work experiences from different hospitals, who have worked in different clinical care, ranging from Surgical, Medical, ICU, Paediatric, Geriatric, and Obstetric and Gynaecological nursing practice. Participants also include leavers with different socio-economic characteristics, health status, family or marital situations, present workplaces and jobs.

Exclusion criteria: Student nurses and auxiliary nurses will not be included, nor will those who left the profession involuntarily be recruited for the research.

The sample size is decided by the scope of study, the nature of the topic, the research design, the types of general questions, the length of interviews and the quality of data (Morse 2000). The review board agreed that in reality, 15-20 is a manageable size for me to complete the PhD study in terms of the time spent on interviews, transcriptions, translation, back translation to check accuracy, and the constant comparative method. However, I kept an open mind about the fact that I might need to increase or reduce the number of participants according to the concepts and theoretical explanation framework which would emerge from the data analysis.

A persistent problem in field work is to figure out who the researcher needs to talk with, listen to, query, or observe about a given issue important to the research. As a former nurse and a nursing teacher, I have personally known many nurses who left nursing, but I hesitated to contact those whom I knew already before the study. I planned to start my sampling with leavers with whom I was not familiar so that I not only broadened my perspective in the beginning, but also could see their views with fresh eyes. If I am new to their situation I can perhaps see it from a slightly more external perspective. The difficulty of recruiting leavers, which has been mentioned

by many researchers, was still beyond my expectations, but I needed to avoid simply accepting a convenient sample. I adopted several approaches to recruit potential interviewees. Firstly, I took the opportunity to consult my previous 30 nursing classmates who are currently working in different hospitals throughout the province when I attended a reunion party in August 2009 to celebrate our 15 years since graduating from the medical university. Many of these classmates worked in administrative positions within the hospital and they expressed great interest in my study and actively offered their opinion and suggestions. Secondly, I took an opportunity to consult many clinical nurses who attended a provincial nursing conference in September 2009. Therefore in the early stages of my study, I not only compiled a long list of leavers' names from their colleagues' recommendations, but also obtained the opportunity to be more sensitive before I started the first interview. Thirdly, my personal and professional relationships in nursing, which naturally were well established during my previous different levels of nursing education, practice, teaching and research, provided me with a good social network in different hospitals (Appendix 1), so that more potential research participants continued to be recommended from different resources: I personally could not have made contact with them without previously knowing them and their organizations.

I chose the first interviewee from a long list of leavers, since she was an experienced nurse who had worked in different grade hospitals and most recently left the highest authority Grade Three hospital, which provided the guideline for nursing practice, assessment and management for other hospitals of the province. I did not personally know her before she expressed her willingness to participate in the study. Although participants were identified through personal contacts, through snowballing techniques, and through the recommendations of other colleagues, the selected criteria for the next interviewee always follow the previous interview data analysis in the field. The individuals might be identified if I provided personal information of participants and reasons of sampling individual by individual in a great detail; therefore I have presented an overview of the 19 interview participants in table 6 to summarize the group participants' characteristics.

Table 6: An overview of the 19 interview participants

Age of leaving		Years of practice		Post before leaving		Educational qualification		Family background		Occupation after leaving	
Range	Number	Range	Number	Range	Number	Range	Number	Range	Number	Range	Number
20-24	2	1-4	4	New nurse	3	diploma	1	Single	2	Housewife	2
25-29	6	5-9	4	Junior post	8	Associate degree	11	Married no child	2	Part-time job	0
30-34	7	10-14	6	Medium post	7	Bachelor's degree	6	Married one child	13	Full-time job	14
≥35	4	≥15	5	Senior post	1	Postgraduate	1	Married more than one child	2	Self-employment	3
<p>Notes:</p> <ul style="list-style-type: none"> The table aims to summarize the group participants' characteristics. There is no intention to provide the range and number of participants for statistical reasons. There are 14 Grade three hospitals among 151 hospitals in the total of 2819 health institution in the city in 2010(Appendix 7). The 19 participants have worked in 12 out of the 14 Grade three hospitals before they left nursing practice. 5 of the 19 participants have left clinical nursing practice but are still working in the hospital in non-nursing roles. They were recruited into the third stage of theoretical sampling from 4 of the Grade three hospitals. The participants have a wide range of nursing practice experience, which include working as a clinical nurse or nursing team leader in the following departments; A&E, ICU, CCU, NICU, ENT, Urology, Haemodialysis, Chemotherapy, Oncology, Radiology, Respiratory, Orthopaedics, Gastrointestinal Surgery, Anorectal Surgery, Brain Surgery, Liver transplantation, Rehabilitation, Endocrinology, Paediatrics, Obstetrics and Gynaecology, and also general medical and surgical units, the Neonatal unit, the 'Retired Cadre' Ward and VIP ward, the Out-patients department and the nursing office in the above noticed different hospitals. 											

The formal interview sampling selection is in three stages. The first stage of sampling includes 6 participants and focuses on selecting as wide a range as possible according to the participants' educational, practice and leaving experiences. "Choosing ideal workplace" and "Losing confidence to ensure safety of health care" surprisingly emerged as analytical categories. At that time, the Vice Minister of Health announced a great concern national wide, that the Grade three hospitals accounted for the highest rate of accidents (Ma 2010b). There are 14 Grade three hospitals among 151 hospitals in the total of 2819 health institution in Hangzhou in 2010 (Appendix 7). I decided to narrow down and only to focus on the leavers from Grade three hospitals. The second stage of sampling includes 7 to 14 participants who left the hospitals, and mainly follows the indicators from the previous analysis for the next interview based on the constant comparative method. In order to gather data until each category is saturated, the third stage of sampling extended the perspectives to the 15 to 19 participants who left clinical care but are still working in the hospital in non-nursing positions.

I have faced many practical difficulties in the field when I tried to keep the principle of theoretical sampling clear in my mind. The following informal conversations and field notes demonstrate the processes whereby I failed to pursue three data resources according to the spirit of theoretical sampling in the field.

Firstly, the fact is that sometimes the researcher could not recruit ideal theoretical samples in the field due to situational limitations. As an example, many participants frequently mention some negative attitudes of current clinical nurses towards nursing practice. Theoretically, I might include some participants or documents which might provide further data for constant comparative analysis from the perspectives of current Chinese nurses who want to leave but felt they had to stay. I was concerned to attempt to follow the most suitable theoretical sample. One nurse was introduced to me by her supervisor as a postgraduate student since she had conducted a survey with clinical nurses about nurses' intention of leaving for her Master's study in 2008 and she left nursing practice in 2010 near the end of my field study. The following

notes demonstrate the difficulty in approaching such a theoretical sample although I intended to do in the field:

The nurse did not want to talk to me at that time. It may be because the nurses intending to leave did not want the managers know their intention before they actually left; and the nurses who left usually have negative experiences. (Nov 2008)

I know there are complex reasons for their leaving, which could not explain by the questionnaire. It is nice if we can meet together for a chat. (August 2009)

I am very busy just moment... I will contact you when I have time (Oct. 2009).

I have left the hospital now. (Jan.2009) ...I don't have time for the interview. (Feb 2010)

She was knowledgeable about the topic and expert by her virtue of her involvement in the nursing turnover study. Based on her research experiences, this potential participant assumed that the participants in her study had negative experiences about leaving which might be the reason that current clinical nurses who intend to leave nursing were not willing to attend a follow up interview. It was interesting that she did admit that the reasons for leaving are more complex than her quantitative study could explain during her leaving stage. However, although I kept a close contact by e-mail during my PhD study with her, when I learnt that she was in her leaving process in Oct.2009, I suggested that I would appreciate it if she could take precious time to agree an interview by sending the information sheet and consent form. She implicitly refused to join in the interview. As a compromise, I consulted other Chinese nursing literature which focused on the intention of leaving among the stayers as secondary data. However, it is fair to include the field notes as background data in sampling.

Following the previous account in data analysis, another potential data resource might be a document which was voluntarily recommended by a vice president of nursing association, who expressed her enthusiasm about my study when I visited the

nursing office in her hospital. The following informal conversation was given by her permission:

You want to interview the former nurses...Yes, I agree. There is not too much chance for clinical nurses to speak out their concern. I am going to retire and I can speak truthfully now. After so many years as a nurse and the director of nursing, the vice president of nursing association, I would say that our nurses are really miserable. I told you ...last year, the health authority organized all the directors of nursing in Grade three hospitals with the official team to inspect the quality of health care provincial wide. One director of nursing advocated that this time we must to listen to what nurses have to say rather than to do the regular check and give nurses more pressure according to the authority requirement. Therefore, two directors as a team interviewed some nurses in one hospital and afterwards each team wrote a report on what nurses have said. In my team, nurses even were in tears in the interview, they were working really hard. The health ministry declared that our nurses should work hard, but most nurses are doing their best. Why did the government not ask what nurses are doing every day? They did not control the IV and antibiotics, which is the main problem. Nurses are just busy running around the ward dispensing medicine and changing the infusion bottles. That is why nurses could not take good care of patients. The hospital did not increase nurses, but nobody would dare to raise the fact of nursing shortage, unless you were prepared to be got rid of from your position. We all know how the hospitals manipulated the nursing staffing statistics, but we pretended to be blind when we inspected other hospitals, since, if the nursing office did not take responsible to meet the nursing staff within dingbian, they would be directly punished for losing the reputation of hospitals. This time all directors expressed that they should hand the collective report to the authority. However, all investigations and reports were required to be locked in a drawer by the health authority without chance to be publicly released in the end. The health authority did promise to give a public declaration to praise nurses for their hard work in the Nurses' Day, which was the outcome of our hard work... (Field notes Zhang Dec 5, 2009)

Since the interview reports included the information what concerned clinical nurses, theoretically, I needed to follow the recommendation to access the relevant documents for comparative analysis. I was referred by the vice president of the nursing association to examine the content of the existing collective report. However, I was unsurprised that the nursing hierarchy, who were in charge of the documents, refused to share the information with a nursing researcher. They explained that they did not have permission from authority. I tried to communicate with the nursing officer in the Health Authority by introducing my study and got her kind support with enthusiasm. However, the nursing hierarchy persuaded the nursing officer that it

would be dangerous to let me read the report. It was difficult to elicit the nursing hierarchy's complex attitudes, but I eventually failed to be able to include the important documents into the study.

Thirdly, I have tried to collect data by checking the leaving rate of nurses in each hospital as comparative data for further analysis during Jan. 2010 to July. 2010. However, after making a great effort to pursue the further official statistical data by gaining good cooperation and support from the nursing officer and many directors of nurses, I found that the leaving rate of nurses was manipulated by the hospital administration and the official statistics of nursing workforce simply lack of reliability and validity, which has been confirmed currently by the Centre for Statistics Information Ministry of Health on October 21, 2010(MHPRC2010b).

By examining the limitations to further pursue the three of potential data resources, which closely conform with the spirit of theoretical sampling as ideas for analysis, I was convinced of two points by the field experience in data collection. Firstly, theoretical sampling is not only constrained by an unresolved theoretical procedure disputation (see section 5.5), but also limited by the democracy and power control within the realistic situation of the research environment. Secondly, having taken the leavers' accounts of their voluntarily leaving nursing practice in the study, it is only possible to speculate about how the method stands up against other alternatives to explore nursing career decision making process in China. Therefore, it is reasonable to suggest that interviewing leavers is the best choice and most effective way to pursue reliable and valid data under the research ethical considerations, political limitations and time available for a PhD project.

7.3 Ethical concerns

All research proposals involving human subjects should be submitted to a research ethics committee (Habermas 1993). The ethics committee is seen to have a gatekeeping function in gaining access to subjects. It also protects researchers and

can offer them informed and independent advice (*Ibid*). Before ethical approval and access permission is granted the researcher should not directly contact the target population.

I did not use organizational gatekeepers to identify the potential participants from the Research Ethics Committee of Health Bureau of Hangzhou, because I believe that nurses who left their nursing practice are professionals, both within and outside hospitals. They have the knowledge and ability to understand the nature of the study and can decide themselves whether they are willing to participate or not, without any pressure from the health authority. However, since the study is conducted by the researcher in China, ethical approval has been sought by letter from the Research Institution of Social Science of Zhejiang province in China. I was informed by the vice-president of the Research Institution that there is no ethical commitment available in social science research and I can carry out my study in China without their ethical permission (Appendix 5). Ethical approval has been granted from the Research Ethics Committee of the University of Edinburgh after a meeting of the review board in June 2009 (Appendix 6). To safeguard the rights of participants, the researcher carefully considered and followed the four principles of ethical issues outlined by Beauchamp and Childress (2001).

The first core principle of ethical consideration is the balance of benefits, risks and costs of the study (Beauchamp and Childress 2001). The value of this proposed study is underpinned by the belief that the findings of the study will add to the understanding of nursing career decision-making in China from the perspective of leavers. It hopes that the issues identified by departing nurses would serve as a wake-up call to Chinese society to rethink and re-evaluate the social and economic value of nurses' contribution within the Chinese health care system. Hopefully it will improve communication between nurses, the hospital managers, policy makers and the public and hopefully stimulate comprehensive nursing retention strategies to improve the quality of health care from the Chinese nurses' perspective by addressing their concerns. Furthermore, since nursing research from a sociological perspective in

China is in its early stages, such qualitative research based on social science will be a valuable learning process for the researcher as a postgraduate student (Appendix 1). By exploring the experience of the leavers and by learning from their perspective this research will move beyond previous quantitative studies, investigate the present situation and chart future directions for potential intervention. The benefit of research is obviously in the long-term; for personal and professional development, since it will enhance the value of research study and hopefully will contribute to a sustainable nursing workforce management in China.

However, in the recruitment of people to take part in qualitative studies there must be an assurance that the procedures are reasonable, non-exploitative and carefully considered and that they are fairly administered (Nunkoosing 2005). The leavers who act as research participants may be confronted with conflicting responsibilities or duties, so it is vital that their participation occurs on a wholly voluntary basis (Habermas 1993). Also the interview time and place need to be discussed as to their convenience. Their contribution of time and energy should be appreciated. On the other hand, an interview serves as an ‘aid to self-reflection’ for the participants (Habermas 1993: 23). During the interview, the researcher will encourage interviewees to reflect on their experiences. Their personal perspective will be carefully heard and valued. Many participants expressed a similar feeling after the interview:

Do not thank me. I would like to say thanks for your interview. When we are talking, I think I do take the opportunity to examine my nursing career which I never thought through so carefully and meaningfully before in my life. (Bo)

It was disappointed that the director of nursing did not give me the chance to talk with her. (Laugh) If she can...just like the way you talk to me, I should be still happily be working there. (Qun)

Although self-reflection cannot be made an aim of the research interview, it will reduce the exploitation factor. Some participants expressed that they are interested to see the publication of the study. Therefore the final report will be sent to them individually. Providing the information will reward their contribution.

The second principle of respect for autonomy means the participants must make a free, independent and informed choice to participate in the study without coercion (Clifford 2000). The principle requires assurance that research subjects have sufficient information and understanding on which to base an autonomous decision (Kent 1996). The potential participants were made fully aware of any risk or consequences of participating in the research so that they may make the decision whether or not to participate in the research (Kent 1996). Many potential participants were recommended by their colleagues, friends or nursing managers to my study. I always made a phone call to the potential participants in order to explain why and how they were approached and I asked them whether they would like to accept the Information Sheet (Appendix 3) and the Consent Form (Appendix 4) by e-mail or by post. I confirmed that they are totally free to make an informed choice about whether they are still willing to participate in the interview after they have read all the information. The information sheets ensure that they have full details of the study and what their participation will involve. This includes the purpose, method, duration, and possible benefits and risks of the study. No real name or identifying information would be used, thus preserving anonymity and confidentiality (Clifford 2000). The participants have been told that they all have complete freedom to decide whether or not to participate, without overt or covert coercion; also they can withdraw their consent without giving a reason at any phase of the study. Meanwhile, I left the contact e-mail address and telephone number of a senior nursing teacher in the Chinese university where I am employed in case they wish to consult further.

The form of consent ensures that each participant understands the information sheet and voluntarily agrees to participate (Kent 1996). However, although each time I carefully explained the function of the consent form, I only got three signed forms back. One of participants regarded the form as “strange”:

Oh, I am not used to sign the silly name. (Laugh) I will sign it if you need the name. Do you really need it? The British style... well, our Chinese are not so serious... ha-ha!

Most of participants were reluctant to sign their name, and I could understand that many Chinese are used to regarding signing their name on ‘official’ documents as a

negative requirement, which might result in adverse consequences for them.

Therefore, once the participant expressed that they understood the consent form and attended the interview, I regarded it equally as if they had signed their name.

The third principle of non-maleficence suggests that even if research is intended to have a positive effect, the good gained must be weighed against any potential harm, and the benefit must outweigh the risk for individuals and the wider society (Beauchamp and Childress 2001). It may be said that the interview can cause no harm to the nurses, since the risks of participating in the research are no greater than those of everyday life (Morse 2003). However, as issues of privacy are often subtle and misunderstood when unexpected, it is important to think of any vulnerability in the participants or the organization (Sieber 1992). Firstly, the study might point to negative aspects of the hospital and influence the hospital's reputation. Secondly, interviewers may be concerned that criticising the organisation or another individual may result in punishment. Such situations will influence the reliability and validity of the data collection. Thirdly, anonymity could be threatened by detailed description of the main characteristics of their experience or of particular events. Confidentiality of participants will be achieved by using pseudonyms in the report. It is important to consider that neither the interviewer nor the interviewees can predict the details of what will be discussed in advance of the interview. The participants were always keen to be reminded by that they have the right to ask for the recording to be stopped at any time. Two participants did ask me to stop recording when they were talking about some sensitive issues. As part of the follow up to seeking their consent, I offered my field notes and interview transcripts to these two participants for them to remove any part of interview that they would not want included in the analysis, interpretation and report of the research. Actually, one of participants gave her agreement to use her account since she thought that the sensitive information about sexual harassment should not be covered up from the perspective of her current position; but another participant asked me to delete the sensitive content about safety concerns within the hospital since she worried it would negatively impact on her new job reference. Participants' autonomy and privacy should be always respected. I

offered my analysis summary and will send the possible publication back to participants for their comments.

The frequently encountered ethical dilemma which concerns me as a researcher is “should I answer when the interviewees’ colleagues or leader asked me questions about why someone left the hospital?” I made a decision to tell them that I needed to consider the information until I had finished my study and could not reveal anything about the findings, in accordance with the assurances made to participants. Casual discussion of any information relating to the interview and participants must be avoided. Another dilemma is that I knew many people who are working in the same hospitals as the participants and might occasionally get different information about the participants. Naturally, I got some related data which may be different from the interviewees’ explanation as it is from a different perspective. The dilemma is “should I be honest and note them in my study?” I did not simply treat the data as a lie or bias, but wrote it down in field notes as second data, the main focus being on how and why the participants explain as they did within an interactive social environment.

Protecting the identities of the participants was achieved by keeping the digital recorder, notes and transcriptions secure in a locked cupboard and computer which can only be accessed by the researcher herself. The corresponding list of names will be stored separately from the recorder. The recording of the interviews will be erased and transcription files will be deleted after successful completion of the study project. This will be confirmed with the participants.

The fourth principle of justice means that research strategies and procedures are fair and honest (Beauchamp and Childress 2001). The researcher will give information sheets to all potential participants without respect to age, gender, education level or position. The participants have been informed that the transcripts will be available to them if they required checking to ensure that the data is accurate during the study. All participants will have access to the final report and will be encouraged to

comment on it when the study is completed. Once the narrative has been analysed, it becomes the researcher's text as well as the participants. The researcher has to take into account her subjectivity which is informed by her own experience (Bar-on 1996). If interviewees are not happy with the way the researcher has presented their transcripts and analysis, the researcher will check and clarify their position in order to ensure justice.

7.4 Data collection

7.4.1 Interview processes

After I translated the 10 questions into Chinese, I asked a Chinese scholar and a senior journalist who are bilingual to back translate the questions and check the style and meaning of questions in Chinese and English for correction (Appendix 2). I practiced a pilot interview with one of my friends who left clinical care in China and is currently working in UK, in order to know where the research questions could focus on, to get richer data. The pilot study did not include data analysis, since she has left Chinese clinical care for nearly 10 years. But the pilot study made me realize that it might be wise to avoid asking the questions one by one; and it would be more sensitive to start the formal interview with an experienced former nurse who had worked in different grade hospitals in China.

The 19 in-depth formal interviews have been carried out with the voluntary participants in China. Interviews were conducted individually and privately in order to avoid disruption. Once the initial approach has been made, and the participants showed enthusiasm in the study, I gave them the choice of the place they preferred and was more convenient to them. Some of them suggested that they could come to my home for the interview. Some of them invited me to their home. Normally if they did not voluntarily suggest the place, I suggested they have the interview in a tea bar with a private room wherever was more convenient for them. The interviews lasted 2 to 3 hours on average. Before the interview, the researcher will check the functioning of the digital recorder and the provision of supplies; batteries, pens and

notebook. According to Nunkoosing's (2005) suggestion, starting interview with what is familiar and readily available to the interviewee will help them relax, I usually start by introducing myself and asked their background information, such as years of nursing experience, work units, educational level and age. As the interview draws to a close the participants were asked, as suggested by Charmaz (2006), if there is anything they would like to add or comment on. We normally had a relaxed time after the interview by having a cup of tea together, which gave extra social space for participants in case they would like to ask the researcher questions in turn.

It is important to arrange adequate time before moving on to the next interview since data analysis will occur concurrently with data collection (Glaser and Strauss 1967). I interviewed one participant in one to two weeks. Morse (2003) suggests that a follow-up interview is necessary to allow verification and ensure the validity of the information, because rich data can rarely be obtained from the first interviews. However, I felt that it is efficient to get the fullest data by an in-depth interview of 2 to 3 hours. Actually most of the interviews continued as long as the participant was willing to talk (Rubin and Rubin 1995). Although they were asked whether they minded me revisiting if there was a need occasionally, I do appreciate their previous time and do not think that the second interview is necessary, which was repeatedly confirmed by my participants at the end of interview.

Zhu: Do you have any other concern which might relate to your or others' leaving nursing practice, and I have not had a chance to ask yet? "

Xue: (Thinking for a while)I think that I have told you everything I knew. Even if you did not ask me, I already voluntarily told you (laugh). I do not think there is anything else.

7.4.2 Relationship between the researcher and participants

It was surprising to me that the list of questions was seldom asked one by one in the interviews, and the participants seem more focussed than me during the interview. Most times, after I used a brief introduction: "Should we look back at your earlier experience from you entering nursing until you reached your present stage" I only began with an invitation "Should we start from why you chose nursing education?"

Then the interviewer automatically begins to tell me their stories through their entire nursing career. The list of questions provides more like a guideline which lets me feel comfortable in checking whether the interview has basically covered the whole processes of their nursing career decision making. An active question is asked only in the event that a participant does not talk or waits for a question, but that situation was rare. Usually I just followed their talking and conversation while prompting through some questions, mainly based on their answers, to encourage further elaboration and clarification of the responses in each interview. Conversation partnership does not naturally happen to participants. The on-going feedback from participants demonstrates that a trust relationship was a continuing process based on a mutual interaction. Several activities have brought about the positive impact on the relationship of trust between the researcher and the participants, which enhances the reliability and validity of data during the interview.

Firstly, I have considered justifying the credibility of the study by getting mutual trust of each other from the beginning during the process of recruiting them into the study, which has been introduced in the previous section on sampling and ethical concerns. After introducing myself to the participants, I explained the purpose, duration and procedure of the study as presented in the information sheets (Appendix 3) and gave participants the opportunity to ask questions. Then before the digital recorder was switched on, as a reminder of the participants' rights, I briefly reviewed the consent form (Appendix 4) and reconfirmed the chance for them to withdraw at any stage of study without giving any reason. Meanwhile, I expressed that I would be more than happy to exchange any information if they would like to ask me questions in turn after the interview. These reminders are important to establish rapport and enhance confidence between researcher and research participants. I emphasized that any information would not be shared with the person who introduced them to my study and I would not make any judgement on them, since the aim is to learn from their experience and their point of view.

Secondly, it is very important for me to carefully justify myself as a research tool with a full awareness of different roles and positions before and during the study. Although qualitative interviewing is suitable for collecting data to explore the research topic, it is necessary to check if the researcher has the qualities to interview effectively. The accessibility, cognition and motivation were three necessary conditions for the successful completion of an interview (Robin and Robin 1995). The relationship between the interviewer and interviewees will shape the three conditions. How I perceive myself and how I am perceived by others has an impact on my ability to form relationships with those I wish to study. Therefore, I carefully justified the various aspects of “selves” in my research situation as a research tool before and during the study according to Reinharz (1997) suggestion.

- Research-based selves: Being a PhD student in the UK, being a nursing teacher in a Chinese university, being an independent researcher not attached to the hospital and the health authority.
- Brought selves: Being a mother, being a member of a family, being female in her middle age, being Chinese, being a Chinese nurse with different levels of nursing education and training experiences in different schools and different grades of hospitals, being a former nurse with ten years nursing practice experiences who went through the exit process.
- Situational created selves: Being an outsider, being one of leavers like the participants, being a researcher, being a mature student in the UK, being a listener.

It is important to think through how the researcher’s characteristics might enhance or intrude on the data collection and to weigh up the relative risk of culture collusion (Arksey and Knight 1999). As a Chinese nurse who left clinical care eight years ago, the researcher shares a similar experience and culture background with participants, which may help to encourage participants to take part in the research, conveying an important implicit message about credibility and openness. By considering the interviewees as a conversational partner, as Rubin and Rubin (1995) suggested, the partners can direct the conversation and help researchers to make judgments about how to explore issues in more depth. As the issue has been little researched, the

participants may often know more than the researcher of what is and what is not relevant to the topic (Glaser and Strauss 1967). Broad questioning was used in the first several interviews to avoid forcing data into preconceived categories (Glaser 1978). These strategies give respondents more room to answer in terms of what is important to them, and enrich the researcher's understanding of the participants' accounts. However, there is a danger that insufficient explanation or clarification may cloud the researcher because of assumptions created by their shared experience (Hammersley and Atkinson 1995). Meanwhile, the participants also might hold back from giving what they might see as niggling accounts, relying on the interviewer to draw on their own background rather than giving a full and explicit account (Reinharz 1997). Therefore, it is important to seek the Chinese nurses' voice by encouraging them to talk about themselves during the interview interaction. The researcher's perceptions should not be substituted for the participant's own words.

Thirdly, it is important to show attentiveness and to listen actively to the nurses' narrative and be alert for interesting leads. The researcher must be open and supportive but avoid acting in an educational role by correcting participants' information. As a nursing teacher and with ten year's clinical practice in a children's hospital, my colleagues and students comment that I have a good affinity. The majority of interviewers also thought that I was an easy going and trustworthy person, who let them feel comfortable to tell their experience honestly.

We have left now. We are free, so we can speak very frankly. I do not think the issues need to be concealed. I would be glad if these could help to improve nurses' situations. Our nurses are too hard. (Yang)

However, not all participants care about the problems they encountered or created during their nursing career since these issues have been left behind by their leaving. I should not take conversational partners for granted in a trusting relationship and must give thought to the likely circumstances of participants, their possible value system and social worlds, as suggested by Rubin and Rubin (1995). This quote, drawn from an interview, provides an example:

Originally I wondered if you only want to write articles for your PhD. It's just these kind of articles, we know how they are produced (Smile). My mum warned me that I should not say any sensitive things to you, since she was worried that I would speak too much without caution. Now I understand that you really want to do good things for the society. I am willing to tell you whatever I thought. (Ting)

Ting despises “the PhD”, which is similar to many nurses who did not value the person studying for “publication”, due to having witnessed and experienced high pressure to “write articles” without professional values during their nursing career (the detail will be discussed in data chapter 7). Although I did not promise that the study will ensure a “good” result during the interview, I did encourage the participants to “think about if we are patients later...” I found that, both being former nurses, when we think that ourselves and our family members might be patients who would receive caring by nurses within the hospital, the study becomes more meaningful for the participants and they tended to be more frank as conversational partners with a sense of social responsibility together with the researcher.

7.4.3 Recording the data

The interviews have been audio-recorded as suggested by Silverman (2010), which not only saves the researcher from the risk of losing information without taking detailed notes, but also facilitates the conversational style of interview. In order to reduce the bias of the recording method, the need to use a recorder was explained to each potential participant during the sampling stage and, at the start of the interview, the participants were reminded again that they have the right to refuse any content being recorded or included in the study as they wish. There were two participants who asked me to turn off the recorder when they brought some sensitive issues into the conversations. The evidence proves that when the participants have confidence in the researcher's promise of confidentiality and autonomy during the research process, the possibility of inhibiting the participants by using a recorder can be minimized.

I used an unobtrusive digital recorder, which can record 36 hours continuous conversation and which will reduce distraction. The time location function can help

to efficiently review the recording during the process of transcription and save time spent on repeated listening. Although some respondents may initially be self-conscious when the conversation is recorded, they forgot about the presence of recording equipment after few minutes (Robin and Robin 1995).

Charmaz (2006) recommends making brief written notes that can remind the interviewer to return to earlier points and suggest how follow-up questions might be framed. The researcher will take discreet notes at key points during the interview. Meanwhile, during or after the interview, I wrote interview observational notes for reflective analysis which might influence the content and context of the interview by the interactions in the interview situation.

I found that prior explanation could comfort participants' curiosity or anxiety about my scribbled notes by saying that: "the notes writing was just in case I may want to come back to something you said as a reminder". These notes will be completed immediately afterwards; identifying and recording as much detail as possible after the interview to allow reflection on important ideas from the participant. The notes can initiate memo writing (Glaser and Strauss 1967). The detail of memo writing will be discussed in the data analysis section.

7.4.4 Secondary data resources

As mentioned before, I have adopted flexible methods towards data collection in the fieldwork. It increases possibilities to enrich the data resources following the principle of theoretical sampling (Glaser 1978).

Firstly, field notes were made after each visit or call on the phone with the potential participants during the process of sampling. Many telephone conversations occurred with some leavers who could not attend the study due to different reasons. Some of them gave their reasons for refusing interview by giving comments about the study

or their leaving; some of them provided some short content about their leaving on the phone although they could not come for interview. For example,

(Annoyed voice) I did not want to mention the leaving. It has passed and it is meaningless to talk about it again. It did not benefit to me, but may be harmful. Yes, it would be hurt me. Don't judge nurses' leaving as a problem. It is common to choose a different job in any career. Nurses have freedom to choose their career. It is not a problem for nurses' leaving. (A nursing teacher with a master degree)

I did not want to say anything. If I say it, it might damage my relationship with the hospital.... Well you must know many head nurses and director of nursing, so it might be a good exchange that you introduce them to me for my business ... (A medical sales representative in a pharmacy company)

I would like to join the interview, but I am far away from the city now. I had to leave... I felt that I was not suitable to do the nursing job...I am the kind of person "soft fire makes sweet malt", but nursing needs fast which also cannot be wrong. I felt that I was already doing well, but the nursing office said we should not compromise with low standard. I hoped I would be OK after one year, but the pressure still increases without release, which became a daily heavy burden. The income is quite well in this Grade three hospital, but I didn't like it.(An unemployed nurse 2 years after graduation)

Some data was naturally available through informal conversations or observation in the field during the research processes. After the core categories emerged, these field notes integrated as secondary data into the analysis which serves as one of the strategies of theoretical sampling and which enrich a continuing constant comparative analysis by providing the background and context.

Meanwhile, I not only treat all the relevant literature as secondary data, but also include the data naturally available to the research field, such as informal conversations or observational notes made during the research process, the relevant nursing policy, hospital documents, archival data, work or personal diaries, news reports, work contracts or work-exit documents as secondary data, which provide a "rich vein for analysis" (Hammersley and Atkinson 1995:173). Again, according to the constant comparative analysis method which is draws on a grounded theory approach, it is important to emphasise that all the secondary data mentioned above should only start to be integrated into analysis when the core categories and

theoretical explanation model emerged clearly from primary in-depth interview data, which avoids contaminating participants' accounts.

7.5 Data analysis

7.5.1 Transcribing interview data for analysis

There is some debate among researchers as to whether or not it is essential to record and subsequently transcribe interviews verbatim (Glaser and Strauss 1967, Glaser 1978, Silverman 2010). While many researchers suggest that a study is truly grounded only if the participants' quotations are correctly relevant in explaining social processes (Miles and Huberman 1994, Morse 2003); Glaser (1978) argues that accounts of theoretical completeness will be remembered by the researcher in view of theoretical relevance, therefore it might not be necessary to transcribe all interviews verbatim for an accurate description.

I was not convinced by the two opposite reasons for doing so. I agreed with the view of Glaser and Strauss (1967) that detailed description sometimes is not important, what the most important are is the concepts. However, I was concerned that the accuracy of the study should be achieved by basing it on culture sensitivity. Work by Twinn (1998) indicates that the Chinese language is extremely complex and it is often difficult to achieve equivalence of meaning in English. Therefore, it is important to recode and transcribe all interviews verbatim and keep them as the most original data for the researcher to check the accuracy of interpretation and translation during different stages of analysis and presentation by constantly comparing one piece of data with another, back and forward between two languages.

Preparing data is the first step in the data analysis, which begins as soon as data are collected from the first interview. In order to save time, as Easton *et al* (2000) suggest, the interview was transcribed verbatim from the audio-recorder by an experienced secretary, who is efficient at transcribing. After the transcripts are generated, the researcher listened to the recording again to compare it with the

transcripts for accuracy, including the meaning, intonation, and manner of speaking, in as much detail as possible. During this process, notes in *Italic* were also made on the interview transcript to capture nonverbal behaviour by integrating observational field notes. The transcripts will be read to acquire an overall understanding of participants' experiences.

Focusing on generating ideas that fit and work, the data was given considerable thought regarding coding. Glaser (1978:38) defines coding as “conceptualizing data by constant comparison of incident with incident, and incident with concept”. I follow the constant comparative analytic process as outlined by Glaser and Strauss (1967) and Glaser (1978). Glaser advocates two analytic procedures: substantive and theoretical coding.

Substantive codes conceptualize the empirical substance of the area of research, which includes open and selective coding; while theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory (Glaser 1978:55).

7.5.2 Open coding

In this initial open coding step the data was broken down and classified by comparing incident with incident, and then placed in a category (Glaser and Strauss 1967). The logic of constant comparative analysis is to continually ask the question:

“What category or property of a category, of what part of the emerging theory, does this incident indicate?” (Glaser 1978:57)

During the first stage of interviews, the interview transcripts take up only two thirds of the page width to allow ease of coding by hand writing in margin, right next to the indicator, which was suggested as the best way by Glaser's (1978). Open coding maximizes allowing the best fits, the most workable and relevant main categories, to emerge on their own. It allows the analyst to see direction in which the study is taken by the participants before becoming selective and focused on a particular problem. For each category identified, the researcher will label the category and provide a brief operational definition in terms of its properties and dimensions from the

transcription. By using index cards, the code and indicator could be quickly referred to data according to page and lines.

Memo writing was at the very centre of the application of grounded theory (Glaser 1978). Memos were used to immediately record the analysis, thoughts, interpretation, questions, hypotheses and directions for further data collection. They also would be dated, titled by the categories to which they refer, and give reference to the point that initiated and prompted the researcher's thinking (Glaser 1978). Memos will be sorted according to category. This will help the researcher to think through possible relationships between concepts (Glaser and Strauss 1967).

After completing the open coding of the 6 interviews, I stopped data collection for one month. Double coding and peer debrief might be discussed between co-researchers or supervisors during data collection and data analysis, but this was not conveniently available in the field due to the distance from the university. I had asked my husband to open code one interview and made a comparison with my original coding. Although the categories appeared to be similar, it seemed too artificial without adhering to the true meaning of double coding. Meanwhile, I had translated part of one interview into English in order to discuss with supervisors. I had found that early translation might lose the sensitivity of the Chinese language the participants used and the English language might change the original meaning of it without catching the sensitivity of culture. Following Venuti (1998), Temple and Young (2008), and based on the epistemological assumptions of my study, I decided to delay the translation of the data into English during the open coding to avoid the possibility of an early "domestication" and the implications of colluding between Chinese and English. Therefore, I decided to re-code the six interview transcripts into the computer by using NVivo 8 software. The same person open coded the same transcripts at a different time using different technical facilities with a careful and serious attitude, which I regarded as equivalent to achieving the function of double coding.

The design of NVivo 8 is strongly influenced by grounded theory although it utilises different terminology, such as “free node, tree nodes”, to describe the similar coding process as “properties, themes, and categories”, but it is still easy to understand and user friendly. From free nodes to tree nodes, the categories are sorted, conceptualised and stored under a coding hierarchy. The CAQDA software provides an easy way to manage data, which not only overcomes the limitation of memory, work space and physical labour to carry, write and search piles of paper and cards, but also provides an effective way to check the categories, their properties and relevant memo writing which is supported by the code-and retrieve operation (Gibbs 2002). However, it relies on common sense interpretation of meaning of particular segments of text, which might artificially repeated technique labour and distance the sensitivity of concept in constant comparison. My experiences using the NVivo in the later stage confirmed that it would not be particularly useful to continue to conceptualize the categories and fully understand the data, even if the researcher used some of the more complex technique of NVivo. Therefore, once the set of conceptual themes were combined and integrated by a constant comparative analysis, the final categories were identified as “tree nodes” under different subcategories with different dimensions of properties and consistent memo links.

I decided to export each tree node with its content and context, memos into word document files, which has been titled by the name of a category after I completed the stage of open coding. Then I sent the files one by one for translation to a Chinese English translator who did not have health care background in China. I found that the word-by-word translation sometimes did not make sense in English. Therefore, I have discussed and checked the translation for accuracy between Chinese and English with a native English speaker who has well qualified experiences of working between Chinese and English language. The careful correction between Chinese and English during the constant comparative data analysis process increased the rigour of the study during the translation procedures. Although my original analysis was based on word-by-word Chinese, when the hypothesis was well developed, I decided to present the quotes following English speaking style in this thesis. Therefore, the English translation is concerned with equivalence at a contextual level rather than

achieving a word-for-word match (House 2006), which means the participants' quotations in the presentation might not truly match the original word-for-word narrative spoken by participants in Chinese.

After that I only used the computer as an electronic filing cabinet, which is valuable for the organization and retrieval of content (Atkinson *et al* 2003). The constant comparative analysis continues by starting translation and writing. Making theoretical comparisons at property and dimensional levels of categories provides a further way of understanding the material (Glaser 1978).

7.5.3 Selective coding

Selective coding is the process of integrating and refining the theory. Deciding on the core category is the centre of selective coding. After I completed open coding of the total 19 interview transcripts, I started to check and continually compare each incident within the free nodes and tree nodes, and continued to write memos. Glaser (1978) advocates researchers start to sort by writing. By writing, analysts are constantly trying to relate conceptual categories by continually verifying that each code fits. At this point, the memos were transferred onto writing along with the coding, incidents and categories, which allowed cross references with relevant properties.

Writing, together with translation, has taken me 10 months constant comparative analysis of data piece by piece. I did not realize that painstaking translation became a very important process in analysis. Firstly, through reading the data carefully for translation, I found that the original code could or should or must be reconsidered or re-ordered. Secondly, the translation procedure has alerted me early to look for a particular problem or direction which I might focus on or follow, which allows me to focus on "what is actually happening in the data" in order to understand what is actually happening as perceived by the participants during their career decision making. The constant input from the actual writing has forced me always to

remember the idea whereby “researchers are always out growing their precious perspectives on data by constant comparative conceptual coding” (Glaser 1978).

The criterion for choosing a core category is suggested by Strauss and Glaser (1967): it must appear frequently as a central concept which can be related to all other major categories in a logical and consistent way; the name or phrase used to describe the central category should be sufficiently abstract and able to explain variation as well as the main point made by the data; it also should be able to explain contradictory or alternative cases in terms of the central idea. I found helpful the suggestion to constitute the central ideal which provides an understanding and explanation of the overall picture, but the central idea may limit by choosing only one core category.

7.5.4 Theoretical coding

Core categories were named and their conceptualizations described in terms of the particular properties and dimensions that were evident in their data. The naturally available informal data, the documents of the nursing curriculum and clinical nursing records, used as secondary data, will enhance the all comparative analysis process. Later, in the final report one can make comparisons, describing how the conceptualization of data extends or fits with the existing literature both from China and the other countries.

Refinement of the theory will begin by reviewing the two core categories for internal consistency and logic. Additionally, the researcher will look for negative evidence (Glaser and Strauss 1967) or deviant cases (Silverman 2010). This involves continuously revising and refining a hypothesis until it accounts for all known cases without exception. Glaser and Strauss (1967) agree that participants should be able to perceive the story as a reasonable explanation of what is going on even if not every detail quite fits their cases. I provide the main categories and the hypothesis to respondents and ask them to comment on how well the theory seems to fit their perception.

8. Trustworthiness of the study

Lincoln and Guba (1985) suggest four criteria for establishing the trustworthiness of qualitative data: credibility, dependability, conformability and transferability.

Credibility, which is related to internal validity in quantitative studies, refers in qualitative studies to the conscious effort to establish confidence in an accurate interpretation of the meaning of the data (Silverman 2010). This basically addresses the problem of whether conceptual categories have a shared meaning between the participants and the researcher. Dependability emphasises whether the process of study is consistent, reasonable and stable over time and across researchers and methods. Conformability means freedom from bias in the research procedure and results. Transferability or applicability, which is related to external validity in quantitative studies, determines, in qualitative studies, whether the findings can be applied in other contexts or settings with other groups. Bryman (2004) emphasises that qualitative researchers are obliged to provide enough detail about findings to enable readers to determine applicability.

Trustworthiness in this study will be a primary consideration in all phases of the research process; research method design, data collection, data analysis and study result presentation. Deviant case analysis was used to address alternative interpretations of data (Silverman 2010). An audit trail, members check, double coding and peer debriefing are the main techniques used to increase the rigour of the study (Glaser 1978, Lincoln and Guba 1985, Rodgers and Cowles 1993, Silverman 2010).

Firstly, rigour is evaluated according to how well the proposal meets methodological standards for qualitative inquiry (Morse 2003). The researcher aims to understand why nurses leave nursing practice from leavers' accounts by exploring their nursing career nursing decision-making process. A qualitative interview study drawn upon

the constant comparative method has been justified as the appropriate method to answer the research questions. However, Rubin and Robin (1995) argues that the major threat to credibility is the allocation of insufficient time during the period of interviewing to understand the lived through experience of the participants. To potentiate participants' performance the researcher has built rapport and thought carefully about each inquiry.

Detailed description can enhance credibility (Miles and Huberman 1994). In addition to the main data source from the interviews, the secondary resource data, including the literature data, documentation in the nursing curriculum and the clinical nursing records, will enhance the reliability of the study.

Trustworthiness is also represented in the recording methods. Individual interviews generate a vast amount of data but people's memory is limited in the recall of oral information (Christy2005). By using a digital recorder, the interviewer can maintain eye contact with participants and can pay attention to what they say. Recording decreases the danger of forgetting important areas and precise recording achieves completeness and accuracy of data (Rubin and Rubin 1995).

Establishing an audit trail is a strategy for maintaining effective records, which can substantiate trustworthiness (Rodgers and Cowles 1993). Rodgers and Cowles (1993) suggest an audit trail should be maintained to document the researcher's choice and insights and to assist the researcher in demonstrating theoretical rigour. In this study the researcher will use memos as a system of recording as suggested by Glaser and Strauss (1967). Explicit memos provide internally coherent explanations. Meanwhile accurate transcription and translation has increased trustworthiness (MacLean *et al* 2004).

A comprehensive audit trail includes four basic types of documents: contextual, methodological, analytic and personal response documentation (Glaser and Strauss 1967). Contextual documentation is generated to provide a description of the setting, nonverbal behaviour of participants and notes concerning distractions or interruption. Methodological notes can ensure accurate assessment of the dependability of the study (Schatzman and Strauss 1973). All inquiry decisions and rationale will be identified, explained and supported. Analytical documentation is maintained to provide a consistent record of the process of the researcher in coding, categorizing and comparing data and in conceptualization patterns that emerge as the data are examined and coded. Consistent and immediate recording has provided a clear trail that allows both the researcher and the auditor to follow the exact lines of inquiry and discern their relationship to the data.

Member check is considered by Lincoln and Guba (1985) as the most important technique for establishing the credibility in qualitative data. I realised that member checks have limitations. Factors influencing this may include that the interviewees may agree to participation in formal checking processes primarily to meet the expectations of researchers and to be good subjects. The nature of the interaction between the researcher and the nurses, social norms concerning politeness and frank conflicts of interest and need are potential issues (Rubin and Rubin 1995).

Meanwhile, since the researcher is part of the process of producing data as well as assigning meaning to that data, the interpretation of these data nevertheless reflects the researcher's version of their understanding (Melia 1996). Therefore I did not provide the interview transcription and interpretation to the participants for checking accuracy and adequacy, but the participants have been asked if the summary and the major themes emerging from the data reflect their experiences. For trustworthiness, the participants were encouraged that any agreement or disagreement from them will be welcome and valuable. Emergent themes and categories were not only validated by participants in on-going concurrent analysis, and also through the constant comparison with the literature. Further verification occurred through discussion following presentation of the findings at conferences and informal communication,

where nurses recognized categories, and suggested that the findings have relevance for other nurses and may be applicable in other locations.

9. Conclusion

In this chapter, a qualitative study which is based on symbolic interactionism by drawing upon interview data and the constant comparative method is thoroughly justified. With a pragmatic criterion of usefulness in choosing different research strategies in the field, I have carefully justified the rationale and trustworthiness of the qualitative interview study by drawing together the constant comparative method from the grounded theory approach and the flexible process towards data collection following the principle of theoretical sampling. In this way, I have taken with great seriousness the words and actions of the people studied, which aims to meet the requirements of both non-academic and academic audiences as Glaser and Strauss advocates (1967). In order to allow the reader to appreciate of the detail of participants' accounts of their leaving, the study presents the data and analysis in the following chapters 3 to 8 according to the main categories and their themes that emerged from the study (Table 7). It then draws together the underlying linkages in the final discussion chapter by developing a theoretical explanation and understanding based on the two core categories.

Table 7 Summary of the main categories and themes emerged from the analysis of data

Core categories	Main categories	themes
Mismatched Expectations: Individual Vs. Organizational	Entering nursing with unrealistic expectations	<ul style="list-style-type: none"> • Choosing nursing with collective expectations • Restricting realistic expectations of nursing in education
	Working in the ideal workplace	<ul style="list-style-type: none"> • Entering the ideal workplace • Committing to the organization • Struggling with a professional identity
	Losing confidence in the safety and quality of health care	<ul style="list-style-type: none"> • Perceiving the risk in clinical practice • Recognizing the organizational barriers to the safety • Failing to meet expectations of patients
Individual Perceptions of Power	Nursing autonomy vs. medical dominance	<ul style="list-style-type: none"> • Comparing rewards with doctors • Struggling with medical dominance
	Professional value vs. managerial value	<ul style="list-style-type: none"> • Emphasising nurses as replaceable labour • Losing enthusiasm in promotion • Struggling to meet career progress
	Personal freedom vs. organizational control	<ul style="list-style-type: none"> • Lack of reasonable nursing mobility • Limited maternity leave and sick leave

Chapter 3 Entering nursing with unrealistic expectations

1. Introduction

The analysis focuses on the views and experiences among the participants who entered nursing studies at different times under a variety of tuition fee requirements and levels of nursing education. The evidence indicates that the collective expectations of nursing before entering the study of nursing are historically taken for granted by Chinese nursing education. Although it appears that this is not a problem for the recruitment of nursing students under the current expansion of higher education in China, this data chapter shows that entering nursing with unrealistic expectations seems to be contributing to the wastage of Chinese nursing education resources. The unrealistic expectations of nursing were created from the recruitment process and continued to restrict progress throughout the entire process of nursing education.

2. Choosing nursing with collective expectations

By way of an invitation to start the interview, I asked participants to tell me why they chose to be a nurse. The participants were very much aware of their personal unwillingness when they chose nursing studies. The predominating reasons for participants choosing nursing were influenced by the views of parents, their concerns for health care for their families, the social desire to work in the city and the higher educational requirements for careers other than nursing.

2.1 Influence of parents

All the participants were influenced in varying degrees by their parents in their decision to choose nursing. The majority of participants accepted their parents' considerations based on the awareness of financial constraints as the role of daughter

in the family, a factor which was particularly mentioned by interviewees who received free pre-registration nursing training.

Our family has 5 children. I had better school performance than my sisters. As my mum wished, the younger I started work, the earlier I would start to make money. (Sun)

Everyone said that a nursing school was a good choice, as I could work in the hospital after the training. It is a 'Golden Rice Bowl'. (Qun)

Choosing free education in nursing could therefore make savings in the family budget for children's education and also could return financial support for the family when the nurse had a stable job working in the hospital. This group of nurses usually entered nursing schools at the age of 15 to 16 and had school performance that exceeded most of their peers, since, at that time, the academic criteria for the free nursing occupational education recruitment was generally higher than the requirement for students who directly entered high schools in China.

I would like to go to the high school for university education. My dad thought that learning certain skills to get a stable job is enough for a girl (Laugh) but my brother was expected to go for higher education. (...) ⁸The result was that I did not want to study hard in the nursing school, although I still did quite well in nursing studies. (...) I said to my Dad, if he allowed me go to the university, I might be more excellent than my brother. At least, I never end up with so many years hard work as a housewife (Laugh). (Ling)

I was always studying hard and received the award for the most excellent graduate in my nursing school. I had always thought about different opportunities in higher education before I had the chance for further nursing training in the medical university (Chun)

Before the one-child generation, the best and most precious opportunities for higher education were usually reserved for boys because gender discrimination is deeply rooted in Chinese family and society, particularly amongst poorer families in rural areas. This group currently constitutes the main nursing workforce and the majority of nursing leaders in China (Table 2). The group of participants expressed the value of higher education for their personal development. Although they originally

⁸ (...) indicate where words have been omitted, and ... for pauses.

graduated with a nursing certificate at the age of 19 or so, most of them hold a higher degree in nursing or further education other than nursing before they leave .

2.2 Concern for health care for family

The younger group of participants who had to pay the tuition fee for their pre-registration nursing education expressed the view that they chose nursing as a way of working in the hospital, because they were concerned about the health care needs of family.

My parents live in a small town, and they wish to have someone in the family working in the hospital as a doctor or nurse, so that they can enjoy some convenience when they are sick. (Xia)

The reason I chose a nursing school was actually the health condition of my father, which was caused by an accident. I just wanted to learn some medical knowledge to help. (Fei)

Working in a hospital for girls is regarded by parents and themselves as a privilege, because it allows them to take good care of their family under the current inequality of health care coverage within Chinese society. This became an important factor in attracting more students with a rural background from the countryside, whose families were not covered by a free basic health care like the urban residents.

2.3 Pursuing social mobility by working in the city

There is a current popular belief among Chinese society, that working in the city and seeking urban residential status are the best opportunities for young people from the countryside to pursue social mobility.

Many of our classmates studied in the nursing school in order to jump out of the status as a rural resident into an urban resident. (Ling)

I did not want to return to the countryside. If I study nursing, at least I would be able to work in a bigger city. (Chun)

The view of working in the city rather than going back to the rural hometown was often expressed in the study. The expectation of working in the hospital with a stable job as an urban resident has become the major reason for choosing nursing.

Ting is an urban resident in the capital city with excellent family financial conditions. She had to decide to choose nursing studies since she was very sick with a high fever during the national examination day and received unsatisfactory results. She said she felt quite happy to be a nurse during her 9 years in clinical care, but many people still doubt why she chose to be a nurse.

For an urban resident of the City, the requirement of entering the nursing school is much lower than for the students from rural areas. I thought it was good to study nursing, because there is no one working in a hospital in my family. However, my decision to study nursing surprised others in my school(...)The principal of the nursing school encouraged me to quickly improve myself and find another job soon after I graduated. (...)And when I started to work, all leaders who I contacted including the head of nurses and directors would ask me why I wanted to work as a nurse. I was not a bad nurse...I wondered why they kept asking me like that.(...) Maybe just because they thought my wealthy life was different from others. (Ting)

From Ting's description, it seems that the leaders of nursing schools and the hospitals held a common view that nursing mainly attracts girls from relatively poor families in rural areas.

It is true that very few city residents would send their children to nursing school; however, in the rural areas, the students... their biggest dream is to work in the cities. ... So don't worry. There are so many people available. (Ling)

Views similar to Ling's are popular among many nurses as well, which echoes the argument of the Chinese government and hospital management. Nursing has been regarded as a job for people who are from low social class under the inequality of society.

As the only child in their family, Yan has sufficient financial support without having to worry about residential status and health care services. She said she chose nursing by herself since her parents totally disagreed with her.

My dad is a doctor. He wants me to learn medicine. My mum wanted me to study in my hometown. I resisted their decision. Later we compromised after some negotiation. I agreed to choose a medical university in my hometown as my first choice and then I can make any choice I wish. The result was that I was admitted by the medical university. I considered that nursing would be relatively easier than medicine. I also had a desire to go abroad. (...)Many

people said that there was a shortage of nurses in other countries, so it would be easy to work abroad as a nurse. (...)My dad was against my decision for nursing studies. He said: 'What good is it to be a nurse? Nurses are shouted at by doctors the whole day.' So it was my own idea to choose nursing. (Yan)

Yan is the only participant who tried to resist the will of her parents for her course choice in higher education. Yan seems to have chosen nursing in order to be free from her parents' control by working abroad. This exception indicates how difficult it can be for Chinese young people to make independent individual decisions about their career choice in collective Chinese culture.

2.4 Looking for a springboard

Ting and Yan had to choose nursing study since they needed to ensure a position for further education as a priority when they lacked confidence to be enrolled into their favourite subjects. In recent years, the less qualified entrance to the University for Nursing Studies has been taken as a "ticket" to get a degree for careers other than nursing.

I found it was very difficult to survive without at least a college degree. ... You know, no matter what, you work for a degree first. (...)I am not interested in nursing, but I must accept the offer and complete the study. (...)I wish to find another job, but if I could not, it must be the two places, ICU or Emergency department. (Ming)

We worried about today many young girls only hope to work as a nurse for a few years after graduation and seek a good marriage so that they can leave. (...)Actually some nursing students have clear goals when they came to the hospital as interns. 'My dad has found a job for me in a financial company... I am doing the internship only for the degree.' (Ting)

Under current high unemployment pressure in the Chinese labour market, competition for the college entrance examination has been regarded as a precious chance for young people to get a good job in Chinese society. Chinese students normally have their parents' full financial support to complete their higher education, but they only regard nursing education as a springboard for a good marriage, working abroad other careers or.

2.5 Advising the potential nursing students

The leavers were frequently consulted by the current potential nursing students for advice on choosing nursing. Their attitude and the values of nursing have impacted on the young generation in choosing nursing. The willingness to enter nursing has been highlighted as the most important pre-requirement of being a nurse.

I would ask why they want to study nursing. Do they like to work as a nurse? If they only need a job or they think that nurses are like angels, I think they must think carefully. (...) Really, unless they love nursing, I would not suggest they study nursing. (Xia).

Nurses should be people who would like to be a clinical nurse in their life (...) I will tell her my experience and let her make her own decision. If you really don't like the job, you just quit the job. (Bo)

Nursing is a noble job. Really, I mean what I say, but it demands sacrifices (...) It will be very difficult for the young people, especially the one-child generation. Without high morality, nobody would like a nursing job. (...) I feel that we should let the young people make their own decision and parents should never make decisions for them. (Yun)

It would be great, if a person really loves to join the nursing profession like Florence Nightingale, a person who has a good family background and is willing to be a nurse. (...) If they are prepared to do the hard work, I still would suggest they choose nursing. (Yuan)

Based on their nursing learning and working experiences, the majority of leavers advised that young people should be fully informed about the nature of the hard work of nursing and make a free choice on becoming a nurse. The participants' suggested that young people should not choose nursing if they did not personally expect to be a clinical nurse. Participants thought that whether or not a person has a realistic expectation of nursing it is crucial to keeping a stable nursing workforce.

3. Restricting realistic expectations of nursing in education

3.1 Creating unrealistic expectations from enrolment

Nearly all of the participants did not have a clear idea of nursing before they entered nursing school and were not fully aware of the realities of being a clinical nurse.

Giving a brief introduction to the subject will be helpful in understanding the nursing enrolment in the Chinese education system.

Nursing student enrolment criteria have changed historically. There are five classes of nursing enrolment according to the national entry examination results for higher education in China currently. The 1st, 2nd and 3rd class students enter bachelors' degree education, but the 3rd class students need to pay extra tuition fees. The 4th and 5th class students enter associate degree education in the colleges. Meanwhile nursing diploma education is provided for students at the age of 16 to 17 before they enter senior high school. Unlike the nursing school which previously had the privilege of selecting the most qualified students from their peers, the current nursing students for the nursing diploma⁹ normally just finished nine years of compulsory free education but are less academically qualified or financially able to afford to continue senior high school to pursue a possible higher education. Entering the 21st century, Chinese higher educational institutions were encouraged by the government to receive tuition fees from the students instead of offering free higher education which was previously fully supported by the government. Therefore the opportunity to enter higher education dramatically increased while different levels of education between the universities and colleges became fiercely competitive in order to attract more students for their institutions. The nursing education institutions currently adopt different strategies to attract more students into different levels of nursing studies.

Firstly, the reality of being a nurse in clinical care was deliberately blurred in the nursing recruitment process, especially for nursing at 1st and 2nd class bachelor's degree programme level.

The benefits written in the recruitment document were pretty good. It talks about nursing research, nursing education, and nursing management, but it didn't say that you would work as a clinical nurse. (Rao)

⁹This group of nurses with a nursing diploma was not included in my study because there is less chance of them working in the Grade three hospitals according to the hospital current recruitment requirement, as the findings of the study indicate.

It seems that the different images of nursing, which were created in the enrolment phase, were not subsequently clarified during their theoretical nursing education. As a 1st class bachelors graduate, Yuan described how her classmates' attitudes to nursing changed during their pre-registration nursing studies in the medical universities.

In the first two years, nursing students and medical students took the same courses and examinations together. Our classmates studied hard and we had a very good academic atmosphere. Our average examination results were much higher than those of medical students. (...) Then we were separated in the clinical learning stage. For each disease, usually the doctors gave the lectures first and then the head nurses introduced the nursing strategies of the diseases at the end. I found that nursing was not difficult and we could learn by ourselves. (...) At that time the senior students came back from their work placement and we realized that we still would become clinical nurses under the orders of doctors. One of the senior students went for a Master's degree in medicine, which gave us hope of leaving nursing, so the majority of our classmates began to prepare for the medical postgraduate entrance examinations. (...) There were 30 classmates in my class, only 5 to 6 of them are still working as nurses, 10 of them became doctors, and the others became nursing teachers. One of the classmates graduated with her master's degree in medicine and went back to work in nursing, but she soon left and worked abroad. (Yuan)

The 1st level nursing students, who were closely trained with the medical students in the medical university, were mostly regarded as the best qualified nursing graduates in China. From the learning experiences of Yuan and her classmates, it seems that nursing education following the medical science orientation has led nursing students to gradually undervalue nursing. Most of them felt frustrated that they could not use their medical knowledge in clinical practice although they thought that they had equal academic capability compared to their medical student peers. Nevertheless the good academic foundation seemed to increase the possibility that the 1st level nursing graduates went for further postgraduate study in medicine, work abroad or other careers outside of nursing. It is not surprising that the nursing education programme in top universities currently has to face great challenge, since they could not enrol enough students. The university where Yuan graduated simply closed undergraduate nursing programmes.

It was interesting that when I had nearly completed the interview with Yuan in a conference room of the hospital, a group of nurses just came into the room for a meeting. From the observation of their social greeting, as a former nurse with a doctorate degree in medicine, Yuan was regarded by the nursing leaders and the nursing colleagues as a successful model for nurses. These former nurses who left clinical care and became doctors, teachers, or worked abroad usually had excellent school performances and, due to the nature of their job and personal contacts, the nursing teachers and new nursing students have regarded them as role models and encourage students to study hard in universities in order to leave clinical practice, which has negatively impacted on the morale of nursing.

Secondly, the ideal of working abroad as a nurse was encouraged in Chinese nursing education.

By encouraging the possibility of working abroad, many students were attracted into nursing studies by the schools, but there is no equivalent curriculum support in many schools. Learning English became the important task during nursing studies, although it is not enough for graduates to be qualified for working abroad. Meanwhile the cost of training for working abroad is too expensive for Chinese nurses, since most of them are from relatively poor families. (Rao)

As a nursing teacher, Rao confirmed that working abroad has been used by the Chinese nursing education institutions as a strategy to attract more students into nursing studies. This strategy has resulted in the educational institutions increasing their investment to focus on increasing Chinese nurses' English capability. The English educational strategies which were heavily highlighted in Chinese nursing literature further support the view of Rao. However, as Rao pointed out, the limitation of English language capability, combined with the economic and realistic conditions do not support the possibility of working abroad for most Chinese nurses. The difficulties in working abroad were realized by several participants sooner or later.

I just thought that it was easier to find a nursing job abroad, but the university provided nothing relevant to my dream. (Yan)

Everyone describes such wonderful images of working abroad↑ (Laugh). The visiting health staff from America in the hospital also told me that there is a shortage of nurses in USA. (...) I thought that it would be great if I could work abroad, at least I could have a chance to travel the world and gain more experience in my life. So I took the TOEFL test twice but failed. (Sun)

An international company told me that I could start as a nurse intern in Maryland, and then I could get a USA green card after I passed the CGFNS and TOEFL and became a registered nurse. So I'm going to go wandering the world. (...) I did not have time to prepare for the TOEFL tests. (Bo)

Many nurses realized that working abroad is just an illusion, which was created by their teachers, private overseas recruitment companies and the widespread website advertisements, although working or further studying abroad has been used to attract Chinese nursing students into the university. The intense English courses in Chinese nursing curriculums seem to have become a kind of wastage of limited Chinese nursing educational resources.

Thirdly, although nursing is an unwelcome career choice in current Chinese society, involuntarily transferring students into nursing studies from other subjects has been taken for granted to increase the number of students at different levels of current nursing education. The difficulty of refusing this redistribution agreement has been frankly explained by Rao, who told me that she needs to secure an offer from the medical university.

I was quite confident to be admitted in medicine. Although I did not think about any possibility of entering nursing, I agreed on the requirement of being "re-distributed" to other subjects. (...) It would cost too much if I chose to take the national examination in the next year for medicine study. (Rao)

The unaffordable cost of refusing the re-distribution agreement with the university offer and taking the national examination again was supported by Yan and Ming, who had to choose nursing after they learnt the lessons from their unusual disobedience.

Because the first time my score was not high enough and I was 'distributed' to a university far away, my mum asked me to refuse the offer and prepare for the examination in the next year. I was under greater pressure... I did not do very well. Ah, I wept (Laugh). (...) Everyone thought that I would have no chance to enter a university. At last I chose nursing. (Yan)

The tuition fee for the 3rd class bachelor programme was too high to afford. I did not want to spend another year reviewing the courses for university entrance. (...) But it was hard to survive in society without a degree. After two years, I came back to attend the examination again and found the textbooks had changed to a great extent. (...) I did not perform well in the examination. I was allocated a place on the nursing associate degree programme, although I did not choose nursing in my application. I had to accept it this time. (Ming)

Their experiences of taking the national examinations twice further demonstrates how difficult the situation could have been if they did not secure their position in higher education, which could explain why so many students normally agreed to obey the distribution and enrolled for nursing although they did not know or like nursing. Although these participants declared that they chose nursing by themselves, the aim was just for passing examinations as a job certificate.

We thought that studying was just for passing examinations. There is no problem about graduating. I have not thought seriously about being a nurse. (Ming)

I nearly failed. I just did not want to have the nursing lectures. I always missed the lectures and played outside school with one of my classmates who also did not like nursing. (...) The nursing teachers list us as the students bringing most headaches and would not care about our failure. (...) But I had to beg them to allow me to graduate. (Yan)

A lack of proper support for students who involuntarily entered nursing study has a negative impact on students' learning attitudes. Yan became a rebellious student who refused to obey the school rules. She was the only case among the participants who had difficulty graduating on time since she failed to pass six courses. However, she still graduated with a degree by adding an extra year for re-examinations. It is rare that students fail to graduate once they have enrolled at the universities in China according to the internal academic quality evaluation in the Chinese universities. As a male student, Ming felt particularly frustrated although he became the monitor of the nursing class and was rewarded as an excellent graduate. Whether or not they studied well, they did not seriously think of nursing as their future career. It is not surprising that they both left nursing practice within one year.

As a nursing teacher, Rao commented on the universities' strategy by which students were transferred into nursing studies without being truly willing to be a nurse.

Extremely unfair to students, such practice is really harmful. (Rao)

However, she said that the students in certificate or associate degree education level are normally admitted by the college according to their first choice.

Rao: Many students entered the associate degree programme in nursing as their first choice. Their test scores only qualify for the 4th or 5th class of college enrolment....Some students qualify for the 3rd class of college enrolment but they still apply for our school. ...Because they could not afford to pay higher tuition fees for a bachelor programme.

Zhu: Are the 4th and 5th class of students normally from families with poor financial situations?

Rao: Yes, that is true. Many students joined our school for two years further training after they had a three-year course with a nursing certificate. When they came to our college, we increased courses which include Etiquette of Nursing, Housekeeping, Community Care, and English. Then they spent another year in work placement. Their aim was to find a job in the City.

It appears that the 4th or 5th class students chose nursing voluntarily. However, it is surprising that some of them were not willing to find a nursing job although their family financial conditions normally were poor as the teachers confirmed.

Many students don't look for nursing jobs after they graduate. The employment rate in our school is about 70 per cent, although, if they like, they normally can find jobs. (Rao)

The unusually low employment rate in the nursing diploma education and nursing associate degrees became a challenge to their educational institutions, as observed by Xia, who recently left clinical care and has worked as a student supervisor in a nursing college.

Many students don't want to find a job in nursing after experiencing their internship. I doubt how many students really want to be a nurse. Now the school claims that they will take employment as the priority orientation. Teachers are very worried about it since the rate of employment needs to be

met. Some students were arranged to sign fake contracts¹⁰ with some company in the labour market. I would say what a waste! (Xia)

As Xia and Rao indicated, the underemployment of 4th and 5th academic level of nursing students after graduation has caused great concern for the Chinese nursing occupational education. Since nursing students need to pay the high tuition fee themselves, they expected their investment to be rewarded with a better job. According to the current recruitment requirements of the hospital, it is difficult for these low level educated nurses to find a nursing job in the city. As a way of seeking work opportunities in the city, directly re-entering nursing college for a higher nursing degree became an attractive choice for some students with a nursing diploma, and this in turn became an effective strategy for the nursing higher educational institution to increase the number of nursing students. The evidence indicates that an unwillingness to work in rural areas may be one reason for the underemployment. Fake contracts have currently been collaboratively arranged by some educational institutions with some labour companies to reduce the rate of unemployment of nursing graduates for their educational reputation, thus the actual employment of nurses might be overestimated by official statistics provided by the educational institution and government. The unrealistic expectations of nursing which are created from involuntary enrolment in different levels of nursing education seem to be contributing to an extensive wastage of Chinese nursing education resources.

3.2 Effects in nursing education

The participants' ideals and attitudes towards nursing were initially influenced by their nursing teachers. However, there was a lack of positive comment on their nursing teachers from the participants, including the leavers who are closely involving in nursing education.

A surgeon taught us the course. The knowledge was fresh and was expressed clearly with a sense of humour. Everyone was inspired by the lectures. (...)

¹⁰ Fake contract: students who could not find a job sign an employment contract with an intermediary labour company, which has been used by some Chinese educational institutions to achieve high rates of employment.

Nursing courses were not as full of knowledge as medical courses and they were boring. Sometimes we understood everything but the teacher was still repeating.(...)The school teachers can have effect on you. (Bo)

The nursing lecturers and the medical lecturers are really different since they have different knowledge backgrounds. I felt that the nursing lectures were very superficial and just followed the same pattern in the lectures. We could learn by ourselves. (Rao)

Many participants had the impression that doctors are superior to nurses by comparing teachers with medical and nursing knowledge backgrounds. Under the medical science orientation in Chinese nursing education, the ideals and values of nursing were simply not well enough clarified. They were more likely to be motivated to follow medicine rather than nursing in learning.

The majority of participants gave negative comments about the way of learning in different levels of pre-registration nursing education.

I had to recite all the nursing rules every day in the school. One, two, three...I had to remember all points exactly, as the answers are fixed without any space for creative thinking. I actually felt bored when I was still a freshman, so at that time I disliked nursing. (Gao).

How well I have learnt the fundamental nursing... I know all the detailed contents on each page of the textbook and I could recite everything from the beginning to the end. I studied hard, but it is pity that we only focused on one textbook. We knew nothing other than the limited knowledge in one textbook. (Chun)

From their description, the strict and narrow requirements of nursing studies have greatly restricted participants' expectations of nursing since they were required to simply recite the contents of a single textbook. It needs to be noted that current nursing studies have been gradually encouraged to be independent from medical education in some universities as part of on-going nursing education reform.

The nursing school merged into the university, then nursing certificate education quickly shifted to the associate degree programme and jumped into the bachelor's degree programme in a short time, but many nursing teachers are of the same qualification based on the level of nursing diploma education. They had to survive in universities. When they worked to solve their own job crisis, how could they have energy for teaching? (Chun)

Chun criticised that some nursing teachers actually lack professional qualifications to meet different levels of students' expectations of nursing. The fact that the quality of nursing faculties could not meet the rapid educational development has become a main concern in Chinese nursing education. Whilst the Chinese government has withdrawn free education from students, it has provided generous funding to encourage Chinese universities to recruit new nursing teachers with Masters or Doctoral degrees in order to increase the quality of nursing faculties. However, the negative view from the participants who are closely involved in nursing education stood in opposition to the current optimistic view that the quality of nursing education would naturally be improved since many young postgraduates were recruited as 'fresh blood' into nursing education.

Nowadays nursing teachers at least need a postgraduate degree. Most postgraduates became teachers without clinical experience. Some of them are pretty arrogant and always consider themselves superior to nurses. (...) We had a teacher when he gave lectures, he often said that you, nurses, should do this and we, doctors, should do that. However, some nursing clinical supervisors in the hospital might say something like they, doctors, should not do this, which caused the problems. It might be better, if the teacher has more clinical experiences in nursing. (Xia)

As a secretary working in a nursing college, Xia commented on some behaviour amongst new nursing teachers with a postgraduate educational background. Most Chinese nursing postgraduate education was normally supervised under the medical staff in the medical university and they may continue to accept nursing as the subordinate of medicine and underestimate the value of nursing, noted by Zhu (2008). Recently there is an increasing awareness of the importance of clinical care experience to be a qualified nursing teacher, but the regulation seems to be ignored by many nursing educational institutions without a full understanding of the value of clinical practice experiences, as Rao witnessed.

Nowadays, according to the criteria of education evaluation, nursing teachers were required to have a clinical certificate and a teaching certificate. But the postgraduates without clinical experience could get the clinical certificate by passing the examination although they did not have to practice as a clinical nurse. (Rao)

When young teachers accept theories from the school with limited nursing practical experience, some of them may tend to regard teachers as superior to clinical nurses.

Shao graduated from her Masters Studies in nursing in Australia. She offered a somewhat different view about the intense theoretical lectures which are encouraged in the Chinese universities.

There are many problems on the current bachelors' nursing curriculum, but these would not be changed under the current nursing education system. I suggested to cut the hours of theoretical lectures and to give students some free time for independent learning or thinking, but it is impossible since the senior teachers need to increase the lectures for their income. What a shame! So I can only keep quiet. I was the same as you with enthusiasm for nursing...but I regretted having further nursing education now. I do not believe that doing research can change anything (Shao)

As a nursing teacher with a Western postgraduate educational background, Shao pointed out that the Chinese nursing teachers received bonuses according to how many lectures they gave, which is why teachers competed for more lectures that occupied students' learning time and limited their wider reading and creative thinking. She regretted taking further education in nursing since she did not think that her individual efforts could change the situation.

Xia bluntly suggested:

I would like to suggest to my students that they should learn more knowledge during their nursing education in preparation for leaving. If you have other chances, you don't have to be a nurse all of your life (Xia)

From the participants' view, without enthusiasm in nursing among the nursing teachers, higher levels of teacher qualification and higher levels of education of students may not equally motivate the nursing students' enthusiasm for being a clinical nurse.

The evidence indicates that the negative impression of higher nursing education is quite prevalent among the current Chinese nursing workforce, particularly for the participants with bachelor's degrees. They did not feel confident about their learning in clinical practice.

As new graduates with a bachelor's degree practice in the hospital, people thought that they were less knowledgeable in theory than doctors, and also they were less skilful in techniques than the experienced nurses. They would wonder why you should be treated well!(Yan)

Yan did not value her undergraduate nursing education. Nevertheless, her undervaluing of her bachelors' degree level of nursing education might alternatively be interpreted as her inability to learn, since she was the only participant who regarded herself as a bad student. However, other graduates with excellent nursing learning performances also did not think that there was a clear educational advantage with a bachelor's degree in nursing.

I could feel their resistance after I entered the hospital. They would say that nurses with bachelor's degrees are no better than others (in low sad voice). We felt that they were just like 'the fox that could not reach the sour grapes' (Smile). (...) But if I am very honest, I really do not know what the advantages are of having a bachelor's degree in nursing. Someone said the ability to carry out a research project, but I felt I was no better than those with diplomas. (Rao)

The head nurses said that we were not as good as nurses with diplomas both in practice and in communication. I felt a sense of failure that I did not gain anything from the university. (Bo)

It is difficult to say whether good training for nurses is necessary. Certainly, the new bachelors' degree graduates have an advantage since they started nursing training after the higher school, which provided a wider knowledge base. However, although most new graduates have a bachelor's degree and previous nurses only have a nursing diploma, most previous nurses with a diploma were pretty smart and capable since we were selected from the top students among our peers. (Chun)

Nursing higher education is not only undervalued by nursing colleagues and managers in the workplace but also by participants themselves. Although Rao felt uncomfortable that the nursing colleagues and managers resisted new degree nurses, she did not value her bachelor's education from the first academic level of university as better than her colleagues with a lower level education. This conflicting view about educational advance was further explained by Chun, who is working as an administrator in the hospital. The current nursing managers are mainly from the generation of nurses with an initial nursing diploma, which may explain the persistent view among the current Chinese nursing managers that the new graduates with higher education are not better than the previous nursing diploma education.

There was a lack of clear understanding and open communication between the different generations of Chinese nurses with different educational backgrounds.

However, in Grade three hospitals, one criterion to improve the hospital's quality evaluation was that all nurses under the age of 45 were required to have a bachelor's degree. Many participants without bachelors' degrees have attended further nursing learning programmes to update their qualification in their spare time following the hospital requirement as a normal rule, although they did not value and enjoy nursing learning. Chun felt disappointed that she spent great time and energy in different levels of post-registered education, but she did not think that the repeating education and hard learning had helped her professional development.

Actually, you'd be better not to choose further nursing education in the university. I had studied 4 or 5 times in different levels of previous nursing education, including 3 years of nursing diploma education in nursing school, 3 years associate degree programme in the medical university, several trainings for an advanced nursing qualification and a self-learning program for a bachelor's degree which I did later.(...) As a matter of fact, most nursing knowledge is always the same as I have studied in the nursing school. (...)I mean all the courses I had learnt...and the quality of all teachers in the university was similar to those in the nursing school. It is true. Choosing further learning in another area would be more valuable than in nursing studies. (Chun)

Without properly updated knowledge to meet their personal and professional development requirements, nursing post-registered education did not attract clinical nurses. A few participants refused to accept the compulsory post-registered nursing education.

I have never tried to continue nursing studies after graduating with a nursing certificate, because I just felt that the different levels of nursing textbooks only simply repeated similar content again and again. While medical theories, such as knowledge of pathology and physiology, was only partly understood (in nursing). We need more efforts if we need to learn it truly well. Meanwhile, I feel that what we learnt from many medical theories such as those of pathology, diagnosis and treatment plan are rarely used by us in clinical care. The director of nursing told me that it was a pity that I refused to attend the further nursing learning which has caused me to miss the chance to be promoted. In fact, I do wish to develop myself by further studies, so I try to find some books which I am really interested in. When I picked up the books in Law studies, I did enjoy them and passed all Law examinations in three years as an intellectual challenge for myself. I was

happy to be a full time nurse while I acted as lawyer for one of my friends, who ran a successful business, as a part-time job. (Gao)

The educational experience of Chun and Gao indicates that lacking a clear vision and curriculum design for the different levels of nursing education not only negatively influenced participants' enthusiasm in their pre-registration education, but also continued to erode their motivation for further nursing learning during their career. From the participants' perspective, they expected that their nursing education and nursing teachers could provide the knowledge that the clinical nurses needed and their educational investment could help their personal and professional development.

3.3 Clinical supervisors' effects in work placement

Whilst all participants except Yan had good marks to pass their examination, the school educational system did not facilitate students to be well prepared for working in the real work environment. Frustrated intern experiences were common among many participants.

It seems that so much busy theoretical learning was not enough for practice. To be honest, the internship in the last year was really painful. (Ming)

When I was in school, I had not expected to face such complex events which were different in clinical care. (...) The work task is fine for me to complete. Maybe I was not prepared to deal with interpersonal relationships in the workplace at that time. (Fei)

The Chinese nursing curriculum put all theoretical learning together based on a very tight lecture schedule and left the work placements for the final year. Many participants thought that the content of nursing studies, based on the current nursing curriculum, could not meet their clinical requirements well in the health care working environment. However, although some participants did talk about their painful experiences during their internship, I could not find a single negative comment about clinical supervisors throughout all the interview transcriptions. Compared with the negative comments of nursing teachers, the participants gave very positive comments to their clinical supervisors.

The clinical supervisors let me feel nursing is an honorable career; I was inspired by them. (Yang)

As students in the hospital we had many chances to learn. Some nurses could do so well in their special area. Nurses like them could do so excellently, I admired them. (Bo)

Participants valued their clinical supervisors' responsible attitudes to nursing, the understandable communication and supportive learning experiences. This might be explained by the fact that the majority of participants acted as clinical supervisors before they left, but three of them had not yet had a chance to be clinical supervisors since they left within 1 to 3 years of nursing practice. Yan was the only one who declared her school performance caused her difficulty in doing well in a very demanding work placement. It surprised to me that she also gave very positive comment on the clinical supervisors when her previous passive learning attitude was challenged:

The clinical supervisor was strict and always asked me questions. In one month at the emergency department, in order to answer her questions well, I used to read books until midnight and got up at half past five in the morning. Although it was a hard time, I would really thank her, because without her I did not think that I would have studied hard and improved so quickly. If my teachers were all like her, I would be a talented nurse. Later I was in the ICU.(...) I really want to work in the ICU as I liked the supervisor very much. She was very capable and knowledgeable nurse and she believed that I could do very well. (Yan)

Participants expressed their appreciation that their clinical supervisor gave more clinical relevant education and personal suggestions for students than their nursing school teachers based on their circumstances and the reality of clinical care.

I did not feel cared for by teachers. (...) I would say that the clinical supervisors were much better than the teachers in the university. (li)

The clinical supervisors in the Grade three hospitals are selected from the most qualified and experienced nurses. This selection is regarded as an honour by clinical nurses. From participants' descriptions, clinical supervisors seem more important than the nursing teachers as nursing models for their students since they are more realistic towards their career and actively provided their personal support and advice to help the students to deal with stress. The following conversation further illustrates the point:

Ting: I would not tell the students that nursing was not a promising career. I would suggest they learn how to protect themselves both for the safety of work and their own well-being. You need to avoid being hurt by your own good will.

Zhu: Being hurt, what do you mean?

Ting: Yes, nursing education encourages autonomy, but when you actually could not do it, you may need to avoid the dangerous schedule first.

Zhu: Some nursing teachers worried that students would be scared if they talk to students about the difficulties of the reality of nursing.

Ting: Actually I think it should be openly discussed with students. If the teachers told me the real situation, I would accept the realities and I would have some preparation for possible clinical frustration, which might reduce the stress.

The contributions of clinical supervisors partly reduced the gap between theory and practice, which participants did appreciate. However, it also means that the clinical supervisors' attitude towards their nursing career might be more powerful than their teachers in influencing students' attitude to nursing and career decisions.

The clinical nurses encouraged us to leave a nursing career since it was hard. (Yuan)

I would tell the students that they should prepare more knowledge when they were young and, if they had another choice, do not work as a nurse. (Xue)

Some participants said that they received the suggestion to leave a nursing career from their clinical supervisors and also they gave the same suggestion for their students as supervisors. It could be that, the more respected and experienced nurses left, the more negative the impact on their colleagues and younger nursing students. From the participants' view, their leaving starts from their negative impression of nursing education and work placement, because nursing education did not support their enthusiasm for personal and professional development in nursing.

4. Summary of the 1st data chapter

Before joining the nursing workforce in clinical care, participants' expectations of nursing were closely influenced by their interaction with their parents, teachers, and

clinical supervisors through the process of enrolment, school learning, and clinical work placement. Whether the participants actively or passively chose nursing, the participants rarely expressed their personal expectations of nursing other than voicing concerns over the collective expectations: the chance of free education to reduce family financial burdens, a stable job working in the hospital with the privilege of health care, achieving social mobility by working in the city and gaining the credentials of higher education as a “ticket” to careers other than nursing. The different approaches in choosing nursing that emerged from the interviews indicate that current Chinese nursing students mainly came from relatively poor families, especially in the countryside. The collective expectation of nursing was historically taken for granted in Chinese nursing student enrolment. After nursing training had to be paid for by the students because of the expansion of Chinese higher education in 21st century, in order to attract more nursing students, Chinese nursing educational institutions deliberately blur the reality of being a clinical nurse, transfer unwilling students from other subjects into nursing studies and emphasise nursing as a chance to work in the city or work abroad. From the participants’ points of view, they were more likely to be motivated to study medicine rather than nursing following the medical science orientation. The strict and narrow requirement of nursing studies not only negatively influenced participants’ enthusiasm in their pre-registration education, but also continued to erode their motivation for post-registration learning. Participants generally appreciated the support from clinical supervisors in their work placement. However, the chain reaction could not be ignored: when there is low morale about nursing among current nursing teachers and clinical supervisors, their suggestions to student nurses for leaving clinical care have a negative impact on the stability of the potential nursing workforce. From the findings of this data chapter, the enrolment and educational strategies have not only resulted in a great wastage in different levels of nursing education, but also exert more challenges for a stable Chinese nursing workforce in the future due to the increased, pre-entry, unrealistic expectations of nursing.

Chapter 4 Working in the ideal workplace

1. Introduction

During the interview, participants frequently regarded their nursing job as the job ‘working in the hospital’ rather than ‘working as a nurse’ or ‘nursing practice’ in describing their previous job. This data chapter focuses on analysing how the participants experienced and perceived the reality of working in their hospital as a clinical nurse. Three themes emerged, which provided an explanation of why all participants more readily accept the organizational identity than the professional identity of nursing and how these employment and work experiences interacted with their decision in leaving nursing practice.

- Entering the ideal workplace
- Committing to the organization
- Struggling with a professional identity

2. Entering the ideal workplace

2.1 Getting priority to choose ideal workplace

Participants with different levels of nursing education background regarded the Grade three hospitals, which are mainly located in provincial capital cities, as the ideal workplace for nurses. Ming articulated the ideal nursing employment choice.

Maybe it would be easier to work without high pressure in the community health centre; it might be easier to find a job in some private hospitals; but I did not consider them. ...I looked for the big hospitals. The biggest hospitals are the Grade three hospitals.... Working in the Grade three hospitals means that, the income, working environment and different aspects of development would be better. (Ming)

Private hospitals and Community Health Centres apparently do not attract Chinese nursing students. The opportunity to work in the Grade three hospitals for new

graduates means a stable job with a decent income, combined with better opportunities for personal and career development.

The deep impression from this study is that all leavers (except one) are the top students or excellent student leaders in their schools. The top students had the priority of choosing their ideal workplace with their school's recommendation.

I was always the No. 1 student in the school, and I was rewarded as the most excellent graduate, so I had the privilege to choose a hospital I liked. (Chun)

The ideal workplaces for the best educated and qualified nurses are generally accepted both in educational and clinical settings. Yan was the only one who said she nearly failed in university.

I needed to apply for one year's extension of study in order to pass the failed courses. I could not apply for a good hospital without the school's recommendation... My boyfriend's dad knows a very powerful person, the Secretary of the Communist Party in the hospital. His dad might think I am a good student and let me choose (hospitals). I chose the most famous one. To be honest, we just depend on such social connections. Later, I learnt that other nursing interns in this hospital were all selected from the most excellent students of their schools. (Yan)

It was unusual that these hospitals accepted students with poor school performances but strong social connections to the hospital authority. The previous employment policy, which supported full employment for nursing graduates, has ceased since 2000, which means that the supply and demand of the nursing workforce should be adjusted by the educational and labour market. The government has not only stopped free training for nursing students, but has also gradually cut the budget of the hospital, and encouraged both the universities and hospitals to pursue profits from their customers (students and patients) to support their expenditure since 1998. As a result of this financial drive orientation, the ratio of graduates employed by Grade three hospitals has been treated as an important criterion for the school reputation in order to attract more students to their institution; while the Grade three hospitals normally prefer employing nurses who pass the internship in their hospitals in order to save time and budget for job orientation and to speed up the new nurses work

independently. Many participants confirmed that the employment competition in these ideal workplaces starts from the intern selection process.

Because so many nursing schools want to enter the nursing employment market in Grade three hospitals, the school wished us to establish a good reputation for the school. Each student needs very good school performance to reach a certain academic level and the school had to pay 1000 to 2000 Yuan for their placement in the Grade three hospitals. It seems that our school lost the chance in the hospital now. (Ming)

On one hand, nursing students are expected by their schools to maintain a good employment relationship with the Grade three hospitals due to the competitive pressure among the different nursing education institutions. On the other hand, by utilising their position as teaching hospitals, these Grade three hospitals seek free workers from student nurses and new recruits to supplement the current serious shortage of staff. An illustration of this comes from Xue, who described the clinical care situation in the hospital when a great number of nursing students were not available:

Summer is the busiest season for us, because the interns have just gone back to school. I was the only nurse working at the intravenous injection room. I was so tired that I could hardly lift my legs. Usually one nurse will have two interns. They used to give great help in the intravenous injection room. (Xue)

Without the help offered by the interns, even though experienced nurses like Xue felt physically exhausted and could hardly carry on the daily shift work. Several participants remarked that they were required to start earlier in the hospital before they graduated to cover the serious shortage over the summer.

Although the employment contracts are only valid from August, our new recruits are all required to work from May. We only get 500 Yuan per month without formal pay. (Bo)

The 500 Yuan (equal to about 50 Pounds) monthly payment for the new recruits working over the summer is far less than the minimum standard of payment for a staff nurse. However, the students could not refuse to be a cheap worker in the hospital before the legal contract started, as Yan explains.

You do not want to work earlier before graduate? No way. Because they are closely connected with the schools, the priority of schools is to establish

good relationships with the hospital. We must go as the hospital required.
(Yan)

In order to get priority in choosing an ideal workplace and retain good relationships with the Grade three hospitals for the educational institutions, the most excellent student nurses are expected by the universities to accept being cheaper labour and obedient workers and avoid conflict with the hospital managers. Nursing education seems to discourage students' awareness of the rights of being a learner and of being a professional individual with fair treatment in the hospitals.

2.2 Selected by the hospital

These Grade three hospitals are becoming more powerful in controlling selection during the employment procedure, although graduates actively initiate the choice with the school recommendations. Hospital managers take an over-supply recruitment pool for granted by setting up extreme recruitment criteria.

The first compulsory requirement is that applicants should pass the Certificate of English (CET) level 4. Chinese nursing students spent significant time studying English in order to get an English certificate pass as high as possible to meet the employment criteria.

The teachers in the school tell us that English is very important for a good job. I met lots of people who have CET 6 during the interviews. (Ming)

However, no participants thought that the high English requirement for nurses was reasonable, since the language capability did not make a difference to nursing.

↑English is almost useless in clinical practice. It is just a way to reduce the number of applicants, since there are too many of them on the waiting list.
(Rao)

The participants did not believe that the high educational investment in English for nurses was valued by the Chinese hospital for nursing practice and nursing career development, but the language capability as knowledge power increased the possibility for Chinese nursing emigration, which causes great Chinese nursing educational wastage (see chapter 8)

Secondly, unlike nursing recruitment in Western hospitals based on the available vacancies and implemented anytime, the Chinese hospitals normally only recruit new nurses from the graduates once a year. The applicant needs to pass a series of nursing skill tests, theoretical examinations and interviews in the hospital. Although the test results are not open to recruits, the interview is usually collectively carried out by the hospital managers together, as Rao described.

Rao: During the recruitment interview, the president definitely will be there. It also includes the secretary of Communist Party, the head of personnel department, and the director of nursing.

Zhu: Do all of them ask the candidates questions?

Rao: Never, actually they need to interview lots of applicants in a short time. ...Hundreds candidates are interviewed in one day, 5 to 10 people enter together as a group. They do not have time to ask any specific question; otherwise they could not finish it.

Zhu: Then, why is the president in the interview?

Rao: To show the importance of the event (With a helpless pose and smile with a sign from her nose).

Zhu: Importance?

Rao: There are a limited number of nurses that can be employed in the hospitals... (0.2) they normally do not publicly show the result of the tests. Some leaders like to take control of the employment decision. There are secret exchanges for personal benefits, which is a 'very, very rich business'. (...)Exchange power and money.

Chun gave more explicit details about the corruption in recruitment:

Some leaders have their personal purposes, such as accepting money as gifts. 5000 Yuan seems to be needed for entering a hospital. In Wenzhou, I heard that 50,000 Yuan should be paid for a nursing position with Dingbian. (Chun)

The managers of these top hospitals take the authority power for granted in selecting graduates from a big recruitment pool. Although there is a lack of official statistics or legal reports, the evidence from many participants indicates that the corruption in hospital recruitment was a covert rule. Unexpected failure without any explanation is not rare. The lack of transparent recruitment process in Chinese hospitals has caused a collective panic among Chinese nursing students. It is common practice that

Chinese nursing students would send many applications to different Grade three hospitals in order to increase the chance working in their ideal workplace. Therefore, it is not surprising that the most Grade three hospitals usually have to interview hundreds of nursing applicants for limited positions in one day, which has been confirmed by many participants. The number of applicants in one interview created the impression for the students that their limited opportunity could easily be lost and they had to accept discriminative practices in the selection.

Thirdly, the covert rule among the hospital administrators and nursing managers in the current Grade three hospitals is that a new recruit should be beautiful and tall. The appearance discrimination was labelled as “beauty selection” by a group of nursing students, who had just gone through collective interviews in different hospitals recently.

We were asked to report our names and then just pass through in front of all of the leaders in 2 to 3 minutes...it seems a beauty selection since they did not ask any questions relevant to nursing. (Informal conversation notes 2009 Dec 23)

As a male nurse, Ming commented that nursing recruitment was under appearance discrimination as well as gender discrimination.

It is a shame to say, but it is true that your height and appearance are very important.... You know, we just stand and nobody asks you to sit down. We were chosen by them without respect... such kind of feeling is bad. The president of the hospital refused to employ any male nurse in the end. (Ming)

Li expressed her frustration when she and 6 new colleagues were regarded as a good image of the hospital for their appearance in their first year practice.

Li: The director of the nursing said that the out-patient department needs good images. It has been arranged and it is not easy to change.

Zhu: What did she mean by ‘good image’?

Li: Beautiful and relatively taller young girls.

Zhu: How tall?

Li: 1.6 meters¹¹, like me.

¹¹ 1.6 meter≈5.25feet

Zhu: About 1.6 meters? Not too many Chinese girls can meet this demand in China.

LI: Yes, only a few. Well, the hospitals only employ limited nurses. Nowadays other hospitals all demand 1.6 meters. However,

Zhu: Would there be any benefit of a “good image”?

LI: (Nod) in this way, when the patients saw us, they may be in a better mood and be friendly to us. Those who are not good looking, or the senior nurses that have been staying in the hospital for many years may feel that they deserve to be respected and so they tend not to talk to patients in a nice way.

Concerned at not having a proper job orientation in the out-patient department, these new recruits asked to change their workplace. However, their request was simply refused by the director, who regarded them as a “good image” of the hospital. Appearance discrimination not only undervalues new nurses’ enthusiasm for nursing but also undermined their professional value and identity.

Fourthly, although all new nurses were required to do the same job as full time staff, the hospital did not provide equal work conditions for all recruits. There are three classifications which depend on whether they are permanent nurses within or without *dingbian*, or temporary nurses with contracts. Li is one of the contract nurses.

In the year we graduated, the hospital was being expanded, and it employed about 100 nurses. Most of us without dingbian... About 20 were permanent contracted nurses whose treatment was almost the same as our temporary contracted nurses. Their health care insurance is lower than recruits within dingbian.(...)I feel that is really unfair, You know I did the entire job the same as the others. At that time my salary is just 655 Yuan per month, which was only half salary and one third of the monthly bonus of the new nurses within dingbian, and I did not have a provident fund and seasonal bonus like the permanent staff. (Li)

Although Li’s work contract may be not the same as other contracted nurses, since there are different regulations between different hospitals, doing the same job with different payment existed in different hospitals. Nowadays only a few graduates with a bachelor degree could be employed in some Grade three hospitals within *dingbian*. Some hospitals did not provide *dingbian* for nurses now. However, all the new recruits could only get a formal reward as permanent staff when they achieved three

years' work experiences. Qun has accepted even less pay than a new recruit when she was transferred from the low grade hospital.

After our previous hospital merged into the later hospital, the first three month we were paid a bonus of 300 Yuan, however busy and how well the work was done, which is less than their new recruits, who have 1/3 of bonus in the 1st year, then 2/3 in the 2nd year, after 3 years we all have the same treatment like permanent staff. (...)The ideal is not about the difference between 300 and 1000 Yuan. It is about whether they accept my work or not. If they gave me the total bonus, I felt that they accepted me as a valuable member of the team and they recognized my capability in nursing. That is means we are equal. (Qun)

As an experienced nurse, Qun felt it was absolutely unfair that they did the same job but had to accept three years unequal pay like new recruits. While, as a permanent new nurse within dingbian, Ming accepted three years unequal pay without complaint.

I can accept that. All new recruits are almost the same. It is a common practice in all the hospitals. The hospital managers take our vulnerable position as new recruits for granted. (Ming)

This highly competitive selectivity implicitly forces new recruits to accept discrimination and unfair contracts with unequal pay in order to obtain a position in the Grade Three hospitals. The data indicates that the hospitals managers have taken the selectivity for granted in order to recruit the well-educated and best qualified nurses but have not been concerned about creating an effective skill-mix work team with different educational levels. The recruitment processes have forced the new recruits to accept organizational identity but has undermined their professional nursing identity in an unprofessional employment environment.

3. Committing to the organization

3.1 Accessing health care for family

Most participants expressed concern over their family's view of working in the hospital as a priority so they can have access to good quality health care.

Since I am from the countryside, I feel that my job working in the hospital can benefit my family members and relatives' health care. This factor stops me think of leaving the hospital. (Chun)

My husband already quit his job as a doctor from a local hospital but he thought that my hospital is a good hospital and asked me to stay for family convenience... Then I hated him. I felt that he did not understand my suffering and did not care for me. (Xue)

Working in the hospital for their family constrains nurses who intend to leave nursing. Several participants did not mention the importance of working in the hospital for their family during the interview; but, except Ming, this group of interviewees themselves or their husband are still working in the hospital, so it may not mean that their unspoken view is different to others. As a single male nurse, Ming left hospital after one year and currently works as a consultant in a health insurance company. He actively kept certain privileges of working in the hospital by establishing social connections with his previous colleagues.

The hospital is a huge organization with 1200 staff. Although I left the hospital, I still have regularly contacted many friends in the hospital. We have very close relationship and play together. I ask for help and support whenever I have any personal or work problems and I also help them when necessary. (Ming)

Through the social connections with current hospital staff, Ming can still enjoy convenience both for his new job and personal health problems. Nurses who are working in the Grade three hospitals became ‘precious resources’ for their family, relatives and friends, since nurses can help them to get safer, easier, cheaper and more effective health care services or even take advantage of the health insurance, which the public might not be aware of or understand within the current health care system in Chinese society (More detail see Chapter 5).

3.2 Gaining a stable job as women

Working in the top hospitals was regarded by some participants as a stable job, which was a suitable occupation for women.

We were educated from our childhood by parents and the schools that we need to have a job by our efforts as women, right? Working in the hospital is a stable job. (Ling)

It is a risk that a woman relies on her husband or friends, so I had to stay in the hospital. I must be self-sufficient before quitting my job in the hospital. (Gao)

Most of the participants believed that women should be financially independent in their own occupation. Ming thought that working in the hospital was a good job for women, but did not believe that nursing was a desirable occupation for a man.

Females, certainly should work well as a nurse. You do the job with a stable income. It may be hard, tiring, but if you work well, it definitely benefits your family and yourself. (...)For a man, I should first ask him whether he is willing to work hard in the hospital or he has other ideas. If you accept the job from your heart and so does your family and your friends around you, you should work hard because nursing also has its career development. (...)There were 4 male students in my class. Two of us never worked as nurses after graduating. I left after one year. Now the only one of us who works in the hospital is the one who most disliked nursing. He always asks me to help him leave nursing, but I tell him that it is not easy to find a good job with decent income outside of the hospital.(Ming)

This opinion that nursing is a job for women is common in Chinese society, which brings more social pressure for male nurses. Although both educational and clinical settings have tried to encourage more males to join the nursing workforce, the particular high rate of male nurses' leaving in China has not been fully understood or resolved.

3.3 Attaching to the hospital within *dingbian*

Working in a hospital with *dingbian* has been regarded as a crucial factor in stopping nurses' leaving the organization. *Dingbian* in the Chinese personnel management system means a stable job with a relatively satisfactory income compared with staff without *dingbian* in the same institution. Although the contracted nurses said that the nursing income was not very good, the majority of participants within *dingbian* were generally satisfied with the amount of nurses' income in the Grade three hospitals. By comparing their income with others working in different occupations, the following extracts provided an overview of the nurses' income level.

Yang: The income working in the hospital is not bad. My twin sister works in the IT industry in Beijing. My income was higher than that of my sister in the year I quit my job (in 2009).

Zhu: Would you mind me asking how much your annual income was?

Yang: I did not remember the exact figure, but it was around 80 to 100 thousand Yuan¹². My sister was above 70 thousand.

Zhu: I remember that you chose nursing study at the age of 16, and your sister went to the high school for university?

Yang: After nursing study I began to work at 19, she continued 3 years in high school, 4 years in bachelor education and 3 years master's education. She started to work at 26 and she has worked for 3 years after graduating with a master's degree now, but she could not earn as much as me until recently she became a manager in the IT company(in 2010).

Yang was quite satisfied with her relatively higher income in comparison with her twin sister, a successful IT employee with 7 years more educational investment than her. Other participants also confirmed that the income from the Grade three hospitals is generally satisfactory compared with others in the current employment market.

You can make 50 or 60 thousand a year. How many people in your hometown can make so much? My brother said that it would be the same to work in any place as long as I could make money. (Xue)

Nurses' annual income in our hospital ranges from 40 to 60 thousand. The nurses in other hospitals can make 80 to 100 thousand Yuan. My sister-in-law is a lecturer in the University (One of the top universities in China). Her annual income is about 50 to 60 thousand. The income of nurses is higher than their nursing faculty and some other academic staff in university. At present, university graduates' average annual income is only 30 to 40 thousand and it is very difficult for most of them to find a job ...actually, nurses' income is fine. (Ling)

From the comparison of income, participants generally thought that the income of most nurses working in the Grade three hospitals within *dingbian* was generally higher than the average population income. It seems that the nurses' income within *dingbian* is not the reason for their leaving but is the reason why most nurses stay.

Ling typified the position within *dingbian* when she considered leaving nursing practice.

Most staff are contracted nurses, who would be fired first if the hospital needs to cut staff. My job is generally stable as a permanent nurse within dingbian. My colleague told me that 30 contracted nurses left the hospital in

¹² Yuan is the unit of Chinese currency (RMB). £1 ≈ 10 Yuan

the same year of my leaving. Many nurses left but the majority of them without dingbian. No matter what, I felt that it was pity to give up dingbian... At that time I was reluctant to leave. (Ling)

The high rate of contracted nurses' leaving was widely reported by Chinese nursing literature. Contracted nurses could not have equal pay and welfare for doing the same job as the permanent staff within *dingbian*. They did not commit themselves to their organizations with a sense of belonging. It is not surprising that once the contracted nurses got chance to leave they would leave without any hesitation.

3.4 Expecting doing a good job

It is impressive that nurses usually did not leave nursing practice at the most difficult time in their nursing career as they perceived it.

Yan: The first year was tough for new nurses. I have passed the hardest time. The personnel staff thought it was a pity for me to leave now.

Zhu: So, busy and tired in your first year as you said, had you thought about quitting at that time?

Yan: Never. Because everyone works in this way, we do extra work almost every day. Everyone in our ward is the same.

The clear answer of Yan quite surprised me. However, other participants also expressed that they had not left nursing at their most difficult time for similar reasons.

The nursing occupational pressure in reality is higher than I expected. I did not think about leaving at that time, because everyone grows up in this way and the problems I have are not only my problems. So I believe that if others can go through it, then I also will. That is how I get used to it gradually. (Yang)

Actually the hardest time for me was when the original hospital merged into the Grade three Hospitals. My daughter was very young and I got lots of books to study (Laugh)...I had never thought about quitting the job. ...Why? At that time, I tried to persuade my friend, 'so many nurses have already successfully transferred to the Hospital, why could you not keep going.' (Qun)

When the participants encounter difficulties, they are comforted by a collective image of nurses and believed they could pass the difficulties through their efforts,

which helped them to be tolerant and manage to stay in nursing. All participants appreciate the chance of working in the Grade three hospitals and try to do a good job at the beginning of their career.

When I started to work in the hospital, I never thought that I would leave the hospital. As it was not easy to get the job in the hospital (...)I was determined to do the job well with all my heart until retirement. As a new nurse, I should be more diligent. (Xue)

Although I do not like nursing, I did pretty well in all aspects working at the ICU and became a team leader after working 3 years. I was even better than some senior nurses. (Xia)

“The beginning” is frequently described as the first one to three years, although several participants mean a much longer work period before they started to think of leaving. It seems that many participants had a sense of strong organizational commitment although they still lack nursing commitment. Most participants felt happy that their job was recognized by patients.

Although I did not like the nursing job, I will try my best to do it well, as I have chosen it. I took my duty seriously. Do you know who asks me to stay? It is patients! They thought that I was the best nurse. (Ling)

I was nearly moved to tears as the patient was so grateful to me that she did not know what to say. It was something very emotional and I never forgot it. The patients recognized my work. ...I felt that my value is to relieve patients' pain and try my best for the patients. (Qun)

Most of participants were proud of doing a good job, since they could make a difference to patients in their daily nursing practice. It is the patients who make the job meaningful to the nurses in the initial stages of their nursing career. They were highly motivated to study and work harder and very soon became the key staff or team leaders in their hospitals.

4. Struggling with a professional identity

4.1 Gaps between theory and practice

Many participants expressed that they could not achieve the ideals of nursing that they have been taught.

Holistic nursing is impossible in such a situation, although we still practice in the name of holistic nursing but we actually combine it with a functional model on daily shifts. (Gao)

I got high nursing education in the Traditional Chinese Medicine (TCM) University, but the acupuncture and massage are almost useless in clinical care. We just focus on getting the work done. (Fei)

Chinese nursing was theoretically inspired by the holistic care model in nursing education, which was initially introduced from the USA since 1995. Meanwhile, nursing education in the Traditional Chinese Medical University encouraged integration of traditional Chinese medicine into nursing practice. However, all participants thought that the majority of Grade three hospitals did not support the holistic and integrated ideal of nursing in order to concentrate on getting the work done. The priority of acute treatment under the medical model has negatively impacted on the value of nursing.

The importance for nursing is to save life. Some elderly have been sent to the E&T, since he has been here, no matter what problems...doctors just let them sleep here for some days... (0.2) I know that patients need us to comfort and care... (0.3) but to be honest; the total time to contact the patients on a day shift was just about ten minutes. The communication is not good. Because of nursing shortage, we did not have time to communicate with patients. (Xue)

The participants who worked with a wide range of patients thought the quality of care in the acute setting was undermined, not only because of the busy and routinized daily work, but also because patients who should be in elderly care, or palliative care were still allocated as acute patients for treatment.

Some patients in our ICU were waiting for death, such as patients with chronic obstructive pulmonary disease. The medical director was very clear, if the treatment is meaningless for patients' life; he just roughly had a look and turned away to the meaningful patients. We spent lots of time to take care of the meaningless patients, so the result was that we treated patients like documents. I mean we did not treat them as patients with our heart, because you could not improve their situation. I think that they would be better to stay at home with community care rather than die in ICU. ...If I have chance to go back to nursing, I would like to work in community care or a charity hospital. (Bo)

In ICU, the most of time you felt that you have tried your best, and hope the patients get better, but sometimes you could not achieve it. They still would

pass away. They stayed in the unit for a long time and you would feel very upset. Therefore the ICU is not the workplace I like to stay in. (Xia 43)

These patients were inevitably incurable. Sometimes... how could I say that the chemotherapy was effective? ...Some patients died during the chemotherapy. I felt pity for them. So I only wish that I could relieve their pain by providing the PICC properly, which could avoid them suffering the pain by frequent injections in their last hours. (Qun)

The priority of acute treatment under the Chinese hospital management and health care system has restricted the development of nursing professional ideals and clinical practice. Perceiving the fact that the acute treatment did not improve the quality of patient's life, nurses tended to dehumanise the individual needs of patients and focus on tasks rather than a human centred holistic care, but it caused many frustrations among participants in nursing practice.

As the secretary of a nursing association, Jie is currently involved in a provincial project to establish nursing specialist training. She shared her conflicting feelings about the ideals of nursing under the current social and political environment.

If a nurse is able to do it well, it should still be quite rewarding. ... (But) what we have learnt, such as nursing diagnosis and assessment was not used in clinical care now. (...) Currently, the Ministry of Health advocates the "Excellent Nursing Project", which plans to cut all unqualified support workers and emphasises that registered nurses should take good care of patients by doing basic nursing care and also ...The fact is that we don't have enough staff. We even could have done it better if we had more nurses.

As Jie expressed, nurses actually could have done better under their professional standards if they had more staff. Unfortunately, the ideal of professional caring was not supported by the nursing professional body and the Ministry of Health. The CNA and nursing leaders accepted the Government's critical view of nursing and advocated that nurses should focus on basic nursing care to satisfy patients, society and government. As the CNA could not stand up for nurses but accepted the blame from the Ministry of Health, the value of nursing was simply understood as basic nursing care. The well-educated and qualified nurses in the Grade three hospitals continued to struggle with their professional identity under the theory-practice gap without effective skill-mixed nursing team work support, since they could not

achieve their individual expectation of nursing although they had the knowledge and skills to do so.

4.2 Lack of clear role boundaries and skill-mix team work

In order to control the budgets and achieve cost efficiency, the hospitals continue to cut support staff. The importance of clear role boundaries for clinical nurses and skill-mixed team work for an effective nursing workforce has not been formally recognised by the hospital administrators and the policy makers. The nurses' roles expanded without clear boundaries, which was taken for granted by the hospital administrators.

Our hospital did not have enough cleaners, and the cleaners also lack proper training in working in a hospital environment, so sometimes nurses should take responsibility for cleaning and sterilization to maintain hygiene and sanitation of the environment like house keepers. (Chun)

When the financial office found the patients lacked enough money in their accounts, the charge nurses were asked to ask the patients for their payment. It was a tough task. (Yuan)

All the physical therapy for patients' rehabilitation in the orthopaedics unit is done by nurses. The more frequently the equipment is used, the more money the hospital gets, so nurses are very busy operating the different equipment. (Yan)

Normally a nurse who is doing the office day shift would input the doctors' prescriptions into the computer and inform the financial department about the fee collection, but everyone needs to inform regarding fee collection when the office nurse is not available, especially on night shifts. Sometimes I was too busy to inform about fee collection. I had to write notes to remind myself later. In that way, we might miss fee collection or overcharge patients. We were not trained as accountants. It would be clear if a person with special training could be assigned to manage the fees. The schedule was very messy and conflicts between patients and nurses might happen when patients doubted their payments, so we must often check and revise the fee list. (Ling)

There is a lack of enough support workers with proper training within the hospitals. In order to keep the institution working well, the qualified nurses have to take on whatever roles the organization expected of them to fill in roles such as cleaners, accountants, secretaries, clerks, and physical therapists. Without clear boundaries of

the nursing role, nurses have to take on unlimited tasks. Many participants were particularly annoyed that they had to be directly involved in fee collection. A head nurse who left nursing in 2006 has shortly attracted the news attention since the paediatric patients and their parents wrote 17 letters to the media in order to ask for her stay (Fu *et al* 2006). When she was asked why she could not stay, she expressed her conflicts feeling that, as a nurse she loves her patients, her colleagues and the nursing professional job, but she felt shame to face patients with financial difficulty, because she had to consider the bonus of her staff according to the financial evaluation of the unit by the hospital administration (*Ibid*). Many participants expressed the similar sense of shame when they were required to act as the fee collection as a professional nurse, which echoed the head nurse public announcement.

The clear boundaries of the nurses' role seem very difficult to identify in daily clinical care, which created some dilemmas in deciding what nurses should or should not do, as Chun expressed.

Nurses are responsible for informing regarding fee collection, which is not our nurses' duty. As you know, in the beginning the nurses helped doctors in deep vein catheterization, and taking arterial blood samples. Now you must do all of the tasks for doctors as routine work. It is terrible when the responsibilities are not clear. It is difficult for nurses to ignore what they could do well for patients or be a helper for others...I mean when you try to work well, it will become your extra daily work and your responsibility. When there is any problem caused by such situations, the nurses are often blamed. Your good intention is to help patients, but in the end our nurses got more blame... (Chun)

Theoretically, nurses have to be responsible for patients' equal treatment, safety, comfort and effective care as a whole. From Chun's perspective, the different processes connected with the quality of health care for patients are fully understood by nurses. Many experienced nurses do value their nursing experiences and try their best in practice. They adapt different strategies to ensure more effective care than their inexperienced colleagues and become the backbone for others whatever the formal or informal requirements.

Yang was trusted by the head nurse and took responsibility for teaching and training

the student nurses and the junior staff in the ward. Although she needed to prepare the lectures and training schedules in most of her free time, she was proud of it and actively supported less experienced colleagues.

I always arrived at the wards before 8 pm if I had the later night shifts, in case the young nurses on earlier night shifts needed help. When they received too many new patients or needed to rescue patients, they could not cope with the workload. They would wake me up for help. They said that they felt safe if I was there. (...) Sometimes you will feel frustrated doing the job under such high pressure in the current work situations. (She raised her voice and spoke much faster than before, which expressed her strong dissatisfaction). Thinking about the quality of care, sometimes it was unrealistic! The more I kept thinking the more frustration, why? You will find there is no hope. The managers did not care about you as a human being. I felt that we could not even ensure safety. (Yang)

The experienced nurses were willing to contribute their time to support colleagues and ensure the quality of health care. However, taking extra responsibility without clear boundaries may create risks for them due to high physical and mental stress, which has made hard working nurses scapegoats for the unsatisfactory quality of health care. The safety issue will be discussed in the Chapter 5.

Chun further commented that the government's current plans about cutting support workers was not a good idea for improving the quality of health care without considering a reasonable skill-mix for team work.

The Ministry of Health has issued a document to cut all the nursing support workers in hospitals. I would say this is absolutely wrong. 4-year nursing training in universities is for improving nursing care, but many tasks can be done well with less training. I think that the support workers can do something to support the limited number of nurses. The importance is that they should be trained properly. (Chun)

The government expected that qualified nurses could improve the quality of health care and intended to eliminate all unqualified support workers, but the realistic nursing shortage seems ignored by the policy makers. 'Nursing shortage' is not a term frequently used by the participants during interview, which is similar to Chinese literature search results.

4.3 Intensifying individual nurses' workload

The participants vividly described their workload based on the different shifts in their previous daily nursing practice. My main focus is to understand how they manage their daily workload in the different situations with different levels of staffing in diverse wards of the hospitals.

The majority of Chinese hospitals require nurses to work three rotating eight-hour shifts and the work week can extend to 5.5 days. Only full-time employment status is allowed. There are four normal nursing shifts in the majority of Chinese hospitals: long day shifts from 8 am to 12 noon and 2 pm to 6 pm (2 hours lunch break), short day shifts from 8 am to 4 pm, earlier night shifts from 6 pm to 1 am, later night shifts from 1 am to 8 am. Nearly all participants could not tell me the exact number of patients they cared for on their different day shifts since their work distribution was mainly based on a functional nursing model. It is difficult to count the ratio of nurses to patients, which could make possible comparative numbers based on the western definition of the nursing staffing ratio. However, on night shifts, it is common that only one registered nurse is on duty in most general medical and surgical wards and also in the most paediatric and maternity wards. The ratio of nurses to patients is 1:30-60, which is a common requirement on night shifts in China nationwide. The participants voluntarily raised many safety issues due to the intensification of individual nursing work.

Did you know a new baby was stolen from a hospital on the night shift? To be honest, I feel sympathy towards the nurse. There is only one nurse working in the wards with more than 40 gynaecological and obstetric patients, and also their relatives, new born babies in the wards. How could she avoid the crime in such an open work area? She needs to carry out so many tasks on duty. She could be in danger if someone wanted make trouble for her, since she must work alone in the night, right? This is a very important reason for my leaving. I feel nervous about the safety. (Ting)

There are normally over 10 severe patients among 48 patients in my wards. In such situations, it is already very hard to finish your regular work. Meanwhile you still need to rescue patients or receive new patients. (Yang)

The limited numbers of nurses were asked to make extra efforts to cope with the unbearable workload. Different wards try to rearrange the time schedule of the night shifts without increasing available staffing. Li mentioned that there were two nurses working together on night shift at the ward of Respiratory.

Usually one nurse does the night shift in each ward to take care of all patients, but there are two nurses working together in the Respiratory ward, because the patients often died during night shift in this ward. There are over 60 patients, and the majority of them were in a serious health condition. Once nurses have to rescue one patient...there is not enough time to take care of others. However, the two nurses had to work from 6 pm until next morning 8 am. ...Each of nurses looked terrible without a smile. No nurse likes to work there. Most staff frequently had a cold like me. Then it passed to my 1 year old daughter and made her sick.... I was determined to leave the ward for my daughter's health. (Li)

I really suffered from doing the night shift. After the earlier night shift, the staff needed to sleep in the ward until 8 am, since she might need to get up for carrying a new born baby in order to be an assistant for the later night shift staff; while the later night shift staff must arrive earlier in the ward at 6 pm for the same task. They just wanted to reduce the cost of nursing staff, but treated us like a machine. I never fell asleep on the ward. Because nursing is responsible for the life of human beings, we could not stop thinking and sleep immediately. Frequently, after the two night shifts, I got a headache and a cold with fever. I really could not stand it. This is the main reason for leaving. (Ting)

The nursing managers prolonged the night shift work from 7 hours to 14 hours, or compulsorily required the off duty nurses to sleep in the unit to prepare to fill in extra duty. The ward manager tried to improve effective work, but did not increase available staff. It has a negative impact on the well-being of nurses and pushes nurses to leave these units for their health due to unbearable stress. The overstretched night shift has caused panic among nurses. Some participants further expressed that, if they could leave night shifts, they might still be nurses in the hospital.

Most of our classmates said that if they could not find an alternative job, or could not go to study for a Master's, it would be fine to be a nurse as long as they could leave night shifts. (Rao)

Participants frequently commented that the clinical demands on nurses are “worse than before”. The unbearably heavy workload on night shifts has negatively affected the health of nurses and the safety and quality of care.

Furthermore, the hospital continued to increase the number of patients but did not increase the total number of nurses, which was confirmed by many participants in other Grade three hospitals.

We normally have 40 beds in the Orthopaedics ward. You know we usually receive extra 5 to 6 patients each day as a normal task by adding informal beds in the corridor. (Yan)

Have you noticed that, before, usually more serious patients came to the hospital, but now people with minor problem all choose the big hospitals? I felt that nurses did not increase but patients increased dramatically. (Ling)

In fact, all Grade three hospitals accept more patients than the number of formal beds while the number of nurses is only based on the formal beds according to the *dingbian* system which was issued in 1978. The 2008 to 2011 health statistics information provided by the local government as second data further illustrated the facts (Appendix 7).

The participants demonstrated that in order to cope with the heavy workload, it appears that the hospital solved the problem by increasing nurses' work hours. Nurses are required to meet the increasing clinical demands both from the hospital and patients. The majority of participants indicated that finishing all the workload on time was impossible for both novice and experienced nurses. Many participants have to do extra work hours in order to finish the shift work in the hospital. Participants confirmed that nurses in the Grade three hospitals have to accept the fact that they should start work earlier in the morning and finish duty later.

We arrive at the ward at 6:30 am. ... We must arrive at 7 am as the head nurse required, but we were afraid to be late, so we left home earlier in order to avoid the traffic jam....I would start to help patients clean their faces or tidy up the beds. (Bo)

Nearly all participants got to work about half an hour to 2 hours earlier in the morning. This not only became a compulsory requirement for nursing students and new nurses in their first three years, but also automatically became self-discipline for some experienced nurses' in order to cope with the heavy workload in a

reasonable time span. 'Too tired,' are the most frequent words when they think about their nursing job in the hospital. Many participants said that they even have no time to have a drink during their day shift.

The Hospital is so busy that you couldn't even have time to drink water since you started working in the morning. Extremely busy, at that time, I hesitated whether I needed to stay. (Ting)

However, although most of them had to start work earlier each day, they were rarely off duty on time. It was common that the majority of participants still had to delay going off duty by 1 to 2 hours. Xia is an exception. She said that most staff in her hospital could finish all the tasks on time. The hospital adopts 12 hour day and 12 hour night shifts for nursing jobs. Nurses separate into two groups. After one group completes three months night shifts, they change to day shifts. Xia thought that 12 hour shifts could reduce the time for handover and ensure most treatment could be completed during the day shifts. Xia confirmed that, although there was still a lack of nurses in their hospital, most of them normally could be off duty on time. Her hospital was regarded by many nurses as the most attractive hospital for nurses (The hospital will be discussed in chapter 8-nursing mobility)

4.4 Working Stress and the wellbeing of nurses

When participants described their work experiences, the work related stress was mentioned in relation to suicide, depression, fatigue, sleep disorder, nervousness, anxieties and sadness, which directly impacted on the wellbeing of nurses.

I was surprised that two participants mentioned nurses' suicide in Grade three hospitals.

Nurses are under high work pressure. One of my colleagues jumped from the tenth floor of the hospital while she was on duty. (Qun)

The reasons for nurses' suicide might not be as simple as the participants described without investigation. However, the explanation of work-related pressure was well accepted by the participants, as a way to describe the high level of stress among nurses.

Depression is another complaint described by many experienced nurses due to facing the dying of patients.

Everyone knows working in the Haematology Department is rather depressing. The main reason is that most of the patients are incurable. One young patient told me: 'if I can get up I definitely will jump out from the window'. (Ming)

Actually, I don't really like the nursing occupation. Because in ICU, the whole year, there were many aspects which made me feel very depressed. What I mean is not the working pressure. ...I have witnessed too much sorrow of separation in life or death among the seriously ill patients. Sometimes seeing the patient in hospital for a long time, you would feel sympathetic and sad. So I always think that this place is not my ideal workplace. (Xia)

(...) At that time, I had close relationships with the patients. I was the head nurse. I was afraid of the fact that they would leave one by one from our unit... because the patients were in their eighties or nineties. You felt that they were your grandmother and grandfather. I had to watch them dying, which would make me feel very upset, so leaving the unit is good. (Chun)

Sympathy is one of precious characteristics for nurses as emotional labour (Smith 1992). But, without psychological consultant support, the unrelieved sadness became emotional stress to the nurses who had to face death in their daily care.

Many nurses suffered from sleep disorder. As a student supervisor, Jie said that she had to rely on sleeping pills to reduce the fatigue before she left clinical nursing.

I must take them, in order to ensure that I still had the energy on the next work day. After duty, I always did not go home; I must have a sleep first due to fatigue. ...After the night shift, I went to my mum's house in order to get sleep without being disturbed. I regularly took diazepam, while some of my colleagues took stronger sleeping pills... The sleeping pills are useless for me. It is a kind of psychological dependence. Then my sleep disorder gets worse... My family was worried that my health would get worse if I did not leave. (Jie)

Under the high pressure, both physically and mentally, working in the hospital, keeping themselves healthy became a challenge for nurses. While the hospital and

the nursing managers take experienced nurses hard work and great contribution for granted without providing support for staff wellbeing, it may eventually push the precious nursing workforce to leave nursing practice to protect their health.

Nervousness is the most common mood described by the participants.

The more practice I got, the more scared I felt in clinical care. I suspected myself of a kind of compulsive disorder by repeatedly checking medicines. I felt anxious because it relates to the life of patients. (Yan)

Xue thought that the stress could not be resolved within the current daily work environment.

Some hospitals advocate releasing nurses' negative emotional reactions. The pressure of nursing could not be resolved by releasing negative emotion. Why? Today you released your feeling, tomorrow when you are on duty; the mood comes back to you. (Xue)

Nurses are not only under work stress on duty, many of them continue to endure anxiety off duty.

Working in hospital, you would be worried and anxious. Even though you were not in the hospital, you would enter into that subconscious state in advance. (...)I always had such dreams and I was very nervous. The dream just like the details and anxiety I had in reality. Rescuing patients, colleagues asking for immediate help (...) I value the experiences I gained through these years of my practice, but it was the pressure coming from the job and you did not like it. ...Staying in such a condition for a long time is not healthy. You have no other choice but to quit. (Yang)

The experienced nurses like Yang accepted the overburden as their responsibility, but the high degree of anxiety in the long term has a negative impact on the wellbeing of nurses. How to support nurses to cope with physical and emotional stress is an urgent challenge for nursing management in retaining them. However, participants complained that, although nurses are under high work related stress, the nursing managers took nurses' off duty time for granted. Nowadays all nurses need to answer hospital phone calls 24 hours, so that the hospital can call in any staff for extra shifts, studies, training, examinations and meetings when they are off duty. As a young girl in her twenties, Yan thought that the hospital was not concerned whether new staff have time to enjoy their life.

Our new nurses needed to take two examinations each month, one a nursing skill test and one for theoretical examination. The nursing office organized one or two monthly lectures for us. We usually took the course after we finished our day shifts and started from 6:30 pm to 9:30 pm, sometimes it continued till 10 pm. Then there was another monthly meeting in the ward, including patients' case studies, accident discussion and learning new hospital regulations. I rarely got a whole day to rest. I came to the city for one year, but I did not get free time to visit the city until I left. (Yan)

As a new nurse in the first year, most of Yan's off duty time has been used as formal training by the hospital. The frequent examinations, studies and meetings occupied the majority of nurses' off duty time without extra payment, which has been regarded as a way to improve quality of care and nursing professional status by different levels of nursing managers. Both new nurses and experienced nurses had to sacrifice their free time as a professional contribution as the hospital requires. However, when the organization exploited their staff off duty, it left little space and time for nurses' fatigue recovery and work stress reduction by enjoying their personal and family life. It is understandable that when the head nurse called Ting for a regular test in the hospital on her off duty time, she eventually made the decision to resign the job.

I was very tired. Our hospital has too many compulsory requirements for nurses. (Ting)

5. Summary of the 2nd data chapter

To conclude, the notion of working in the hospital expressed by the participants has illustrated how the organizational expectations of nursing negatively impact on Chinese nurses' faith in their employed hospitals and the nursing profession. The extreme selection during the recruitment process in the ideal workplaces has reinforced the successful recruits' acceptance of organizational identity rather than professional identity. The evidence shows that although the ideal work place could meet the participants' pre-entry expectations, it helps the employees establish a strong organizational commitment, merely accepting nursing as just a job for life does not motivate active nursing. Although the participants usually expected to do a good job with a strong organizational commitment, the priority of acute treatment and profit drive in Chinese hospital management has resulted in a great theory-

practice gap in nursing. The ideal workplace did not support individual nurses to achieve their professional values and ideals of nursing. The well-educated and qualified nurses had to take over workload without clear role boundaries and effective skill-mix team working. The work stress under the current unresolved shortage of staff has negatively influenced the well-being of nurses, which in turn negatively impacts on nursing professional identity.

Chapter 5 Losing confidence in the safety and quality of health care

1. Introduction

This chapter focuses on the leavers' experiences and views of risk management and quality of care in the Grade Three hospitals. The majority of participants, who were experienced nurses, regarded the safety issue as the key reason for their leaving clinical care, while the inexperienced nurses, who worked less than three years, rarely commented directly on safety issues. The group of leavers who are still working in non-nursing positions of the hospital hesitated to voice the safety issues compared with the participants who left the hospital. The participants found themselves in a difficult position in meeting the demands of the hospital and the needs of patients in their daily practice. The following three themes emerged from the data and demonstrated why the participants did not have confidence in current safety and quality of care and how these safety and quality concerns impacted upon their decision to leave clinical care.

- Perceiving the risk in clinical practice
- Recognising the organisational barriers to safety
- Failing to meet expectations of patients

2. Perceiving the risk in clinical practice

Two of the participants personally experienced adverse events before they left clinical care. The analysis starts to closely examine their personal encounters with the risk management process and compares experienced and inexperienced nurses' views towards risk management in their workplace.

During the interview, Yun vaguely referred to “a small event”, “a very small thing happened” before her leaving, but she avoided talking about the details. It was interesting that when she talked about how she felt confident in her new job in the very late stage of the interview, she eventually started to talk about the incident. She regarded it as a signal to give up her career in nursing.

If the accident had not happened, I must still work hard as usual. (...) Of course this accident was not the main reason for me to leave. It was just a primer of leaving. I have worked for 14 years with complete trust from my colleagues. Everything had been fine before this accident. I had never thought that it would happen to me. ... (0.2)¹³ (Her eyes were moist with tears) I really criticized myself. I should not make a mistake like this to bring harm to the patients' families, myself, the unit, and the hospital ... (0.5) Such an event made me fully understand what kind of job I was doing. Just concerning the nursing career... I would become older, weaker and less efficient in clinical care. After you have experienced such an accident, it affects your confidence and it is very difficult to get out of the darkness. I felt that there was no value in being a nurse. (Yun)

After experiencing the unexpected accident in her 14th year of practice, Yun began to question the value of staying in a nursing career and doubted whether she could ensure the safety of patients if she continued her clinical care. The long pause during the conversation revealed her sadness, although she left nursing nearly four years ago. However, she declared several times that the accident itself was not the direct reason for her leaving. The following extract further explains the consequences she went through during the event.

Zhu: Would you mind telling me what happened?

Yun: An accident. As a daily routine in the maternity unit, the 40 new born babies needed to have a bath before 11 am. Two nurses worked together at that time: I brought the baby from his mum into the bathroom and another colleague took him back to the parent, but then the two babies' identity labels were mixed up and wrongly replaced before they were sent back to their parents. I thought that I did not pay enough attention at that moment since we did the routine every day. Unfortunately, the colleague who worked with me was also not careful (Husky voice with two hands holding tightly). On the 4th day, the blood type test of one baby was taken because he had neonatal Jaundice, and then the mistake was revealed by the neonatal unit to their parents.

¹³ I used... (0.2) indicate the time of pause when the pause is longer than 1/10 second. Here means the time of pause is 2/10 second.

Zhu: *It is good it was found out...*¹⁴

Yun: *[That is good. No! It was found in the neonatal unit and checked back to our maternity unit. I did not know why all things happened at that time, but someone had to take the responsibility. There must be a person to take the responsibility. I had no choice. I was the team leader and had the duty to do so, right? Otherwise, the head nurse would be in a more difficult situation.*

Zhu: *(Nod)*

Yun: *(...) I took all the responsibilities and I should deal with the issue with the patients well. (...) The crucial point was my attitude. I would do anything the families wanted me to do and would accept any punishment without any conditions. We offered them a single room and our head nurse stayed there overnight to provided one to one care. Later the two families accepted my sincere apology neither sued me nor asked for any compensation. I was really lucky. It was an accident according to the law. Because it was the first time such an accident had been openly reported in our hospital by the neonatology unit and to patients (husky voice), It was absolutely impossible to cover the accident. The hospital leaders were actually nice to me and only regarded it as a “serious mistake” with a financial punishment, which I thought was benign for me. The mistake was not recorded in my personnel file, but the accident would be recorded.*

Yun felt that she must take all the responsibility for the accident as a team leader. To reduce the harm both to the clients and hospital became her priority. She called it “lucky” since she was not sued in the court and also was exempted from an official accident report within the health care system. The accident seemed to be resolved in a “perfect” way with her and the head nurses’ efforts and the families’ kind forgiveness. Yun interpreted the formal punishment which was made by the hospital managers as benign, which supported her view that the accident was “a small event” and it was not the direct reason for her leaving. However, Yun had to face the physical and emotional pressure during the risk management, although she avoided speaking directly for herself, but referred to the impact on others.

Yun: *My head nurse and other relevant nurses were also blamed as making the “mistake”. A financial punishment was implemented on the individual nurses and the whole unit separately by cutting the monthly and seasonally bonus. Apart from these penalties, we were required to*

¹⁴]

[...indicates overlap conversation. It happened during the interview when the participants expressed their view rather than agree on the researcher’s interpretation.

make a statement of self-criticism in front of all staff at the hospital-level conference. Certainly the aim was to remind us of the safety issue. I know that our head nurse was a fragile person at that moment. I said: "Don't cry when you are up there. We still need confidence in ourselves although we made a mistake. " But our head nurse really couldn't control herself and burst into tears at the meeting. (She lowered her voice. Her eyes moistened when she mentioned the crying of the head nurse.) Certainly, she felt wronged. It was understandable. Really, she worked very hard and made sacrifices all her life for the unit without being married at 45 and finally we got such bad luck. (...) She was rewarded with such punishment in public. ... (0.3) I told her: "You are our leader. You must be strong. We will work together to resist the high pressure."

Zhu: Did she mention that the hospital did not give your unit enough staff? (She previously has mentioned reasons of the particular shortage of staff in this unit.)

Yun: At that time... (0.5) (She shook her head, with a long pause). Nobody dared to say... (0.3)

Zhu: And you?

Yun: I had eventually managed to control my tears. I said that I would not cry any more (smile), otherwise people would laugh at me again. (...) I must be terribly unlike a human being in those terrible days. I could not sleep well and recall the experiences of more than 10 years clinical care and asked myself what I originally expected and wanted in life again and again. (...) In addition, many people like to hit a person when she is down.

Zhu: What do you mean?

Yun: Some head nurse or nurses from other units like to belittle you in public. So I did not know if there was any significant meaning to work there. ... I felt that I would make more sacrifices if I stayed in nursing. What about the rewards of more sacrifices? There would be no chance of promotion and it would be impossible to get a good position for several years. What is the significant meaning of working there? After the accident, I must try to understand myself first. I should say it is the positive side of the accident. If the accident didn't happen, I could not leave nursing since I used to think about others more than myself.

As a simple solution, the individual and collective of nurses in the unit were given a financial punishment. The public self-criticising conference not only did not encourage an open discussion and seek to avoid a repeat of the accident by clarifying the organizational barriers, but also gave further moral punishment which implicitly isolated the possible collegial support and encouraged belittlement among the nursing managers and colleagues who were working in different units. There is a

lack of an independent consultant and a professional body whose role it would be to support individual nurses in dealing with the accident. The words which Yun used to comfort and encourage the head nurses indicated her struggle at that moment.

Although Yun emphasised several times that she did not cry, the emotional sympathy with the head nurse revealed that Yun's sadness and feeling of being wronged was the same as her head nurse. The blame culture seems to humiliate the nurses' self-esteem. The individual competence and morale of nursing were greatly challenged without the proper organizational support. The passive and inefficient organizational risk management caused high pressure and tense emotional suffering to Yun, which undermined her good will to be an excellent nurse and be respected for her good professional reputation within the hospital by colleagues. Yun tended to undervalue herself as a valuable member of the nursing profession, which previously motivated her enthusiasm in her nursing career.

Compared to Yun's implicit expression of her leaving being related to the accident, Bo admitted that the adverse event had a great impact on her leaving. As a new team leader, Bo had to face similar high physical and psychological stress after the incident happened in the late night shift. The priority of the risk management in Bo's hospital is as same as Yun's: to focus on identifying the individual who must take responsibility for the incident.

Bo: I was under great pressure to work as a team leader on night shifts. One morning, when we were preparing handover after the whole night hard work, a duodenal tube was pulled out from a patient's body. The tube reached the duodenum by an operation through his nose. It being pulled out meant that the patient had to endure the same operation again. (...) Oh, I was extremely sad. I must take responsibility for it as the team leader... (0.1) and every change of the patient's conditions in the future would be related to you... (0.5) I lost my mind and I was worrying about how to hand over the mess to the next shift. Such a feeling, I just sat there ... (0.3). Later, the head nurse asked me to change the clinical record ...in order to protect me from responsibility for the incident, for example, how agitated the patient was. I had to emphasize the restlessness of the patient by adding such descriptions. However, I made changes several times and I had to make several hand-written copies... (0.2)I was very tired, because I did not sleep after the night shift. I continued doing it until the late afternoon.

Zhu: You did not go to sleep?

Bo: Yes. I could not go to sleep before the event had been dealt with properly. I walked in and out of the rooms again and again, and I already had a headache. I did not know what I was doing. The staff sat down to discuss...the reason was obvious, but I needed to do self-criticism for my mistake on the meeting.

As a new team leader, Bo blamed herself deeply for causing the patient's unplanned extubation and the 2nd operation, while the head nurse wanted to insulate Bo from the responsibility for the adverse event by changing the nursing record. The self-protection and self-criticism under the blame culture both did not provide the space to discuss the possibility of reducing risks. As a researcher, I sympathise with Bo' situation, but I was more interested in what had been missed in the risk management within the hospital.

Zhu: The reason was obvious?

Bo: Yes, he could not calm down. A student was looking after him when others were busy making beds before handover, but he could not be controlled easily. (...)

Zhu: How many nurses were on the night shift?

Bo: We had more than 10 beds. All patients were cared for by a nurse based on one-to-one in day shifts. Five nurses worked on night shifts according to the schedule. (...)I was the group leader, the second nurse was less experienced, the third one was a beginner and the last one was a nursing student, who was not equal to a qualified nurse in practice. Therefore, I had to take care of everyone (including patients and staff), so ...very tired.

Zhu: What was the original Dingbian about nurses in ICU?

Bo: 1 to 2.5, which means that each bed should have 2.5 nurses, considering multi-shift operation. It was the compulsory demand of the hospital. (...)The regulations were not followed strictly. The head nurse made a schedule based on the number of nurses available. There was no clear requirement for a ratio of the nurses to patients of 1:1 or 1:2 in ICU. No such requirement. .

The detail of staffing indicated that the unqualified nursing staff were counted to meet the legislated staffing ratio, which has caused more stress for the team leader. Although the head nurse defended Bo by changing the nursing record, Bo was still degraded as an unqualified team leader. It seemed that both the participant and the head nurse lacked a clear awareness of the relationship between the staffing policy

and safety of practice. Under a blame culture, there is a lack of an effective way for nurses to realize and formally raise their safety concerns during the risk management process without interdisciplinary professional discussion and independent professional body support. Unlike the incident that happened to Yun, the accident involving Bo was covered within the unit without an official report. The organization lost a chance to assess risks by learning lessons from the incident. The same clinical problems could not be prevented from happening to other patients and nurses.

Although other participants did not mention that they had personally encountered an accident during their practice, safety issues were raised by the majority of participants. Ling felt that the stressful working environment caused her health problem, but she still could not ensure the patients' safety.

As the only member of staff in the haemodialysis ward I was responsible for 2 to 3 patients from 7:30 am to 9pm. If you encountered a difficulty in venous injection, you couldn't get a helper. Then during the haemodialysis, if the patients were in emergency, I could not cope with more than one emergency at the same time. At that time, you felt that there was no one available for help. Ah ... (0.5) (She looked down at the ground for a moment, when she continued to talk, her voice was surprised changed.) yes, at that time, I did feel that it should be identified as malpractice. I thought such practice actually put patients' lives in danger↓. Sometimes it was impossible to ignore certain situations that the patients were at risk in, if I was not rescuing another patient. Then the situation might not occur to them ... (0.5).

As one of my previous classmates in nursing school, Ling was quite happy to talk to me during the interview. I was surprised at the unexpected sadness of Ling during this conversation, which was demonstrated by the relatively long pauses and the obvious changes in her tone of voice. She pointed out some malpractice might inevitably happen in her daily practice, but after a long pause she did not voluntarily pick up the conversation first. I reminded myself that I might cause the participants to be uncomfortable or stressed by intrusive questioning for details which they might not be willing to share. Therefore, I decided to continue by comforting her feeling.

Zhu: ... (0.3) You said that there was a shortage of staff. If you were busy what could you do?

Ling: I felt that all the hard work I have done is just for completing tasks, but not for the individual patients. That is not enough. You didn't observe

patients carefully. No time, it is a kind of powerless feeling. ...I was very nervous in such situations. After I finished my shifts, I could not stop going through all the tasks I had done in my mind. It was funny that I had an auditory hallucination for a period since I was staying in the haemodialysis ward. I felt the alarm was ringing around me every day. (Laugh) I could not stay there until my health status got worse. ...Who asked me to stay? Patients! They thought that I was the best one to them in the unit. ...Actually that is us, who are responsible nurses for so many years.

Based on her 18 years of practice in the outpatients department, E&T, and in the general medical, surgical and urological units, Ling was quite confident in her capability in clinical care but laughed at her own nervousness which eventually linked her leaving with her physical health problem. She felt that she had not done enough for patients, since she could not ensure the safety and quality of health care by her best efforts. Concern about safety and quality became the main stressor which directly caused her health problem. Perception of the high risk of clinical practice has negatively impacted on many participants' faith in nursing, since it goes against experienced nurses' expectations of taking the professional accountability for patients' safety.

When a patient was in a critical condition, a good and competent nurse would bring about completely different health results to the patients, which a non-competent or irresponsible nurse would not have achieved. (Xia)

We must work with conscience, since sometimes only you know how much effort you put in to improve patients' recovery rather than just finishing the tasks during your nursing practice. By communication and emotional support, we could be of help to patients... When the patients made a good recovery, I felt that all the hard work was worthwhile and I was proud of myself. (Yang)

The majority of participants thought that a good nurse ought to be more effective in the improvement of patients' health by providing a high quality of health care. As a competent nurse, they believed that they should help patients' recovery by doing a good job based on their skill and knowledge capability. However, some of them expressed their sympathy for the colleagues who experienced accidents.

I heard some accidents happened. Such mistakes are unforgivable since it hurts patients' benefit, but from my perspective, these accidents should not be solely the problems of nurses. ...The mistake just unluckily happened on your shift when you were really busy. You forgot something when you turned

around to do something else. You forget it because you are too tired. This is the chain reaction caused by fatigue, do you agree? (...). Under the current high pressure in the workplace, it was hopeless thinking about the quality of care. The feeling is that I could not ensure the safety. (Yang)

Actually when a person is exhausted, it is very easy to make a mistake. The danger is obvious. It is not only me; lots of nurses could give you lots of evidence. ...Such as accidents, mistakes and conflicts between nurses and patients, do you believe that tired staff can work effectively? ...If it is possible to increase staff by 2 to 3 nurses, the rate of accidents will decline and we will feel less pressure. ...The quality of life will be improved. I had no quality of life when I was a nurse. (Qun).

As excellent team leaders with 12 years and 16 years work experience in different hospitals separately, Yang and Qun were quite confident in their professional capabilities. However, they confirmed that a long state of fatigue has negatively influenced the quality of patients' care and the nurse's life. Yang's view represented many experienced nurses who worried that an accident might unfortunately happen to them.

Nurses cannot defend themselves when we have to determine the share of responsibilities between doctors and nurses. It is really painful for nurses (...) When we have a chance to sit down to discuss the accidents, a formal decision must be already have been made by the leaders. The meeting is not for us to assess the risks. It just arranged in order for us to express our self-criticism (...) Oh, it would negate totally the all good efforts you have done. Nobody would help you. My heart really goes down that nurses are used as scapegoats in the end... The current system couldn't ensure a high standard of work. I gave up since I could not change it. (Yang)

Yang perceived that the individual nurse was powerless to change the safety issues, since there was a lack of proper risk management to support a safe working environment in the hospital under the current health care system. However, they could easily become scapegoats when things went wrong without a professional body to carry out an investigation. She regarded leaving as a way to avoid being involved in possible accidents, since nurses are always the last line of defence for patient safety within the hospital. It has been seen that without justifying the safety staffing issues, even capable and experienced nurses have lost confidence in safety and quality of care by their best individual efforts. The rich evidence from this analysis has demonstrated an undeniable trend among the Chinese nursing workforce: that

groups of excellent, experienced Chinese nurses tend to leave nursing practice since they realized that they could not take professional accountability for patients by their individual effort, but they might lose control over their clinical care in ensuring the safety and quality of care in a high risk work environment.

Compared with the more experienced participants, the participants who had worked for less than 3 years did not directly comment on safety issues in their practice. However, safety issues were indirectly illustrated by their experiences of being evaluated as “a good nurse” in the beginning of their nursing practice both as a nurse intern and a new nurse.

When I was an intern at the ICU, the clinical supervisor praised two of us that we could be good nurses since we could do the job independently with her trust ... Sometimes I did not know how to do it but I asked some young nurses in secret. I would rather understand the things before I do it. But another intern who was also trusted by the supervisor to do the job by herself was too brave. She pretended to understand things she actually did not understand. I really dared not do like her. I felt she was going to make some trouble sooner or later. (Yan)

Being a “good nurse” for a nursing student or a new nurse emphasized that the sooner they get the job done independently, the better evaluation they would be given. However, when inexperienced individuals faced their fears and problems but pretended knowing without asking for support, the potential workforce might start on incorrect career pathways without a clear awareness of safe practice and work environment. The criteria of “being a good nurse” for new nurses affected their safety awareness from the beginning of their nursing career.

As a male nursing intern, Ming said that he had participated many times in rescuing the patients. He described an emergency situation in the cardiology unit where he directly implemented CPR on a patient together with a medical intern.

The most impressive thing happened when I was in the cardiology department (...) Once, a patient with myocardial infarction was sent by the emergency department to our unit on the 10th floor, but the patient had a cardiac arrest again when they were waiting for the lift on the ground floor (...) They waited for the elevator and sent him to the unit. It was Saturday. There were doctors on duty, but they were not in the ward at that time. Of

course, they were called in at once. But at that moment, there seemed not enough staff. A deputy head nurse was the highest level of staff who was in charge of the rescue. A postgraduate medical student and I were male and other staff were female. We were very important and we did the chest compressions very seriously. Our arms swelled... but the patient died. Maybe during the whole process we wasted too much time (Taking a deep breath). The relatives of the patient didn't act against the hospital, but our two male interns discussed the problems of the whole process for a long time. If the rescue could be started immediately, if we had more capability, his life might have been saved.

Ming described the incident as his most impressive experience in his internship. He emphasized the important role as male staff in doing the CPR, but the hospital seems to leave the medical and nursing interns alone to experience stress without a clear risk awareness of their legal professional practice and organizational barriers to the safety and quality of health care.

As a new nurse, Li was evaluated as a good nurse by the head nurse since she was a quick learner in working independently.

The head nurse said that she needs to choose a good nurse from our new recruits as a pair of quick hands due to the shortage of staff. ... after two days, the head nurse let me take all the responsibility independently, such as dealing with severely ill patients, but sometimes I felt I did not do well, especially I did not know how to use the ventilator. ...I needed to take arterial blood from patients for tests, but I did not know how to do it. They just let you practice by yourself on the patients. Then I always failed. Eventually, the head nurse did it with me once. After then I could do it by myself. She was pleased that I could learn more quickly than she originally expected of me. (Li)

Li's experiences indicated when inexperienced nurses lack proper supervision and professional orientation, they might unavoidably make mistakes under the current overload of clinical demands, which inevitably put patients at risk and caused unnecessary patients' suffering. The participants with less than three years clinical care experience have demonstrated that their efforts toward to being evaluated as "good nurse" by just fitting in with the organizational rules are dangerous. It is noteworthy that before Bo encountered the incident, she was regarded as one of the most excellent junior nurses by the head nurse and the nursing office, as she expressed:

In the first 3 years, I really wanted to be a good nurse ...After the incident, there is still some fear and pressure inside. Even if I could become the team leader again, I did not feel confident to do it right. I like to do every detail of the job for patients, but, if I pay too much attention to the small things. I could not finish the tasks on time. I felt a more serious attitude towards the job, the more I felt I could not do it well. To be a good nurse, it is necessary to ignore the small things and focus on finishing the bigger tasks. Some nurses are better than me in this nature. I am not a good nurse. I began to wonder whether nursing was a suitable career for me. (Bo)

Bo expected to be a good nurse by taking care of patients in “every detail” without ignoring the “small things”. However, as a junior nurse who had only worked at the ICU for two years and just returned to ICU after nearly one year working at the nursing office, she was delegated as a new team leader with the head nurses’ trust. Bo lost confidence in her capability to be a good nurse and gave up her nursing career when the incident happened during her duty as a team leader. Bo’s case indicated that the cost of overlooking the educational and supervisory investment within hospitals for the new recruits would negatively impact on the quality and safety of health care. It may be that by developing appropriate clinical supervision and management strategies to support their students and new colleagues, managers could ensure the safety of patients at the beginning of their nursing careers.

Apart from the majority of participants who were worried about the safety and quality issues, it was surprising that the group of nurses who are still working in the hospitals rarely related safety issues to their leaving clinical practice, although they also talked about their work stress like other participants. Sun was extremely horrified at her work experiences in the neonatal department on the night shifts.

Sun: There were 50 to 60 patients. Do you remember the time that two babies shared one small bed, which would not be allowed in other countries, right? One night shift remained deep in my mind. As the only staff nurse on shift, I was responsible for 60 new born babies and most of them with serious conditions. That night I had to hand ventilate with tracheal intubation a baby who suffered tetanus, and meanwhile I still had to admit 5 new patients. I could not even write down any of the new patients’ reports until handover time the next morning. I was crying. I could not cope with it, very nervous, each night shift. I almost collapsed after the shifts. Very, very hard! Later I worked in PICU; I was responsible for 4 to 6 patients on the night shifts, who were all very ill

and needed ventilators to support breathing. I was lucky to leave now. Our nurses work even harder than before. (Sun)

Zhu: What do you think about the safety of patients in such work circumstance?

Sun: Well, there was still no accident yet at that time.

Sun experienced intolerable overload in her previous nursing work environment, but she seemed to avoid talking about any safety issue as an administrative staff of the hospital now. The nurses who are working in the hospital may not freely participate and openly discuss the issues relevant to safety and quality in the hospitals, since keeping harmony within the hospital is the priority when they are still working there. I interpreted her view of patient safety as a tolerant attitude towards the accidents within the hospital.

The tolerant attitude to quality of health care further indicated a low confidence in the safety and quality of health care among the health staff under the current health care system. However, most participants who left hospital could not tolerate the high risk and low quality of health care. Xue criticised the health staff's tolerant attitudes as lacking empathy towards the patients' suffering.

Maybe as staff we might be tolerant (to the mistake), but how could people be tolerant if the mistake or accident happened to yourself or close friends? (Xue)

It would be terrible when I become a patient, I think. I hope the system will be improved and the problems solved in the future.... I advised my friends and relatives don't go to the hospital. I cannot feel at ease (Qun).

Perceiving the risks of clinical care, all participants expressed that they felt uneasy in trusting the safety and quality of the health service in the ideal work place. From the interview, based on their nursing knowledge and experiences, all participants are used to personally accompanying their relatives or friends to see the doctors within the hospitals in order to ensure that nothing goes wrong with them(See Chapter 6). The three different attitudes and awareness of the safety issues among the participants reminds one that the power of the relationship between the nurses and their organization may silence nursing professional judgement about patients' safety. The participants' beliefs and behaviours suggest that the safety and quality of health

care within the Grade three hospitals is problematic and impacts upon nurses' decisions to leave nursing practice from their ideal workplace.

3. Recognizing the organizational barriers to the safety

Participants felt that they did not have enough confidence to challenge the organizational barriers to the safety and quality of health care, although they worried about the safety and quality of health care

As the data indicates, the adverse events experienced by Bo and Yun were covered up within the unit and the hospital respectively. The self-criticism requirement and blame culture stops the staff from challenging the organizational barriers to the safety and quality of health care. Yun worried that the accidents which she experienced had also happened, and might repeatedly happen, to others under the same work environment.

I thought about the mistake. Of course it was caused by my carelessness. Mistakes can easily be made in the baby room at that period of time. Similar cases might happen in other hospitals. Some mistakes might never be found, really! It is caused by the busy work environment. It could not be avoided by a person. We could not be perfect under the stress. (Yun)

By talking about similar accidents that happened in other hospitals, Yun did not think that concealing the accident, without effective organizational solutions and intervention, would avoid accidents happening again. There was a lack of further official records and effective organizational intervention strategies to follow up the adverse events, which prevents health staff, organizations and the health care system from learning the lessons.

Similar, passive strategies of risk management in different hospitals were commented on by many participants.

When they need to deal with adverse events, the first question is whether the patient has already discovered the problem. If the patient doesn't know the problem, it is very easy. Just lets you cover it up. We could not change this.

If we make mistakes and report them, maybe we will be criticised, or punished, so people do their best to hide the problems. (Rao)

Now the head nurse allocated different responsibilities to several team leaders. You have been delegated already, which means that you should do your best to solve or cover up the problems. If the problems are reported to the high-level leaders, they would say that the team leader was unqualified. We do our best to resolve the problems inside. (Bo)

Nurses characterized the system as being closed and concealing. It seems to become an implicit rule that the individual staff and institution tend to cover up the adverse events before the patients and their relatives know of it. Nurses were implicitly warned to keep quiet for the hospital after the accidents. The professional accountabilities to the public were compromised. However, by emphasising the strict signature requirements and team leader delegation, participants felt under more pressure that they were required to take individual responsibilities for all the possible risks.

Yan asked me to turn off the recording when she talked about significant differences in the mortality rate of patients. She explained that she didn't want to get into trouble. I also deleted the relevant field notes as she requested. The priority is that I need to respect her willingness and agree to her request. Yan explained her fear:

A nurse should help patients to resolve their problems, but here you must be consistent with the hospital. When we entered the unit, we were told that the benefit of the hospital is absolutely the priority and we should keep all information within the unit as confidential....Although I have left the hospital now, I might apply for a non-nursing job in a health institution which might need their reference. The hospital is powerful; I did not want to get into trouble. (Yan)

As a new nurse, although she showed her sympathy to the patients, she tended to keep quiet in order to avoid being in trouble since she was taught to keep silent. The power of the hospital over the individual nurse was well recognized.

Qun confirmed that nurses were required to toe the line with hospitals in risk management.

The hospitals currently pay great attention to self-protection. ...It was suggested to nurses to be cautious when we talked with patients and their relatives, because they may use these words against you. When something goes wrong, nurses were required that they should not say inappropriate words. Being afraid of nurses saying something wrong, all of us must be quiet or keep consistent with our leaders. Now there are extra demands in writing nursing reports. We are required to write in standard ways, so we spent a great of time on writing reports in the office rather than being with patients at their bedside. Furthermore, all documents need to get signatures from the patients or their relatives. These mainly focus on how to protect ourselves when there is anything wrong. The patients who have to engage in lawsuits with hospitals are very miserable. (Qun)

The hospitals increase the sense of self-protection by controlling nursing staff's oral expression and written records, but patients' rights are possibly thereby compromised in risk management. It is a common complaint among clinical nurses and the participants that the unreasonably strict documentation requirement took too much time away from nurses contact with patients. However, Gao did not take what Qun called "the standard way" of nursing record for granted as a lawyer now. She pointed out that changing the original medical record is unprofessional and illegal practice.

According to hospital documents evaluation, no modification of records is allowed, therefore, if we wrote a wrong word or evidence, we must rewrite the whole page of the report over several shifts. The alteration of evidence may look more complicated. It is impossible for us to write the reports in the same handwriting among different shifts, right? (...) The nursing office began to ask nurses to regular check and rewrite the nursing reports which were required to be rewritten by different staff. This documents workload is heavier for nurses now, but we have no choice. This evaluation within the hospital is not right. I think we should have more humanistic orientation. It is necessary to improve writing ability and teach nurses to write more precisely in nursing education... but what's wrong with the original records as long as they are clear and easy to read? Why cannot we just highlight the wrong words by red pen and rewrite the right words nearby and sign it, which can be accepted as legal reliable records. (Gao)

Gao criticized the current strict nursing record evaluation that just focuses on clerical errors, but ignores the original nursing records as legal documents. It not only increased nurses' workload, but also violated patients' benefit. Revising the original record has been implicitly accepted by Bo and her colleagues after the adverse events happened, which illustrates the fact that the original clinical record as a legal document seems to be mistreated by health staff and hospital administrators for self-

protection. Without transparent information and public accountability, it is difficult for the public to protect their rights as patients and they normally give up seeking legal support.

The safety and quality of health care was not publicly accountable from many participants' perspective, and there was also a lack of effective monitoring by the health authority in the current Chinese health care system. Xue did not think the regular evaluation from the health authority would improve the quality of health service.

Xue: The external supervision from the health authority could not make a very objective evaluation. Something is invisible. It can be secretly made up. For example, if the provincial Health Bureau comes to evaluate the clinical quality of health care today, the hospital would arrange more staff, right?

Zhu: Yes?

Xue: If there were normally 2 nurses in the shifts, they could arrange 4 nurses today. What did the extra 2 nurses do? They communicated with patients or give health promotion education, such as: "Let me know if you need any help"; "Would you like to drink some water?" Those things did not normally happen in our regular work. It will stop after the evaluation was finished. You see, it is not real. Most of us must come back from extra shifts on those particular days. (...) The result of evaluation not only depends on your performance but is also decided by the relationship between the hospital administrators, nursing officers and the external evaluation team members. Everyone works hard together to pass the external evaluation (...) Just work for passing the inspection. The patients also know that it is not a real inspection. Sometimes they are also co-operative.

Zhu: The patients?

Xue: For example, we told them that we need their co-operation for the evaluation. Of course we talk to the patients who are friendly to us. Those who are not easy to deal with will definitely not be asked for help.

Zhu: Yes, for a good evaluation.

Xue: Actually I think it is enough to do as usual. If you arrange more nurses, the jobs can be well done.

The hospital quality assurance was managed by these external evaluations from the health authority, but these visits seemed not to tackle the real and underlying safety issues. Xue clearly expressed that nurses could do well with enough staff, which

echoed by many other participants. The question might be asked whether the health authority have proper strategies or knowledge to evaluate the quality of care by ignoring clinical nurses' opinions.

As a nursing teacher who is currently teaching safety and risk management in a nursing college, Rao further illustrated that both the nursing educational content and clinical practice experiences could not empower nurses to deal with risk management effectively and with enough knowledge and awareness.

The safety management education only discusses what are the definitions of medical malpractice and non-medical malpractice and the differences between malpractice and uncontrollable situations. Personally, I think that we should analyse why the mistake happened, such as objective and subjective reasons? Is it because of a problem of hospital management? For example, a nurse only can take care of 30 patients, but she is required to take care of 60 patients. Who should take responsibility for the accident? It should be made clear. But, I think it is difficult to say so before students. I mean to blame the management. It seems inappropriate to say that all the problems are hospital problems. ...I have witnessed many accidents in my clinical experiences, but I have never personally dealt with one. The accidents were only discussed by limited number of leaders with the staff who directly caused the accidents, without a transparent discussion. To tell the truth, I still don't know how to deal with adverse events even if I teach the course in the nursing college. Actually it is affected by a wider environment within the hospital and the society. Individually or collectively, nurses did not have the ability to change the present situations. (Rao)

It seems not only that the theoretical learning about safety management in nursing education could not well prepare nurses to face the challenging work environment, but also nurses could not have chances to learn from others mistakes due to the lack of an open discussion and transparent report system for the adverse events. Several participants confirmed Rao' view that they did not know how to deal with an accident since the discussion of accidents is limited among several leaders within the hospitals without transparent investigation and effective solution. It is understandable that most Chinese nurses tend to be passively tolerant of the current situation and obedient to their direct managers.

Several participants expressed that they did not trust colleagues and emphasised the importance of self-protection by their efforts both for patients and themselves. They felt that they could only trust themselves in order to avoid accidents.

The work of nurses is interconnected at every stage. The point is that you must protect yourself. Self-protection includes two aspects. The first aspect is you should keep yourself in a good working state and be alert in work. The second aspect is you must trust your mind in your work. (Yang)

I am the last line of contact with the patients, so I am the person to take the direct responsibility for their safety. ...Although we often need teamwork, I tell the nursing students that I don't trust anything which was done by others. I must check everything myself. I trust my own eyes rather than the others. Many people made mistakes, since they just carried out the last procedure with patients without checking the whole prepare process again, because we are always very busy. If I did not check and trust myself, I might make mistakes following others' procedure. It was dangerous. I will absolutely advise them to trust themselves, not others. (Qun)

While the nurses appeared to trust only themselves for safe practice, they felt more stress, since nursing naturally needs a mutual team work trust. The exhausting work conditions under an overload of nursing practice has decreased work efficiency, which negatively impacts on the physical and mental well-being of nurses and the safety and quality of care. Yang expressed her disappointment, as did many of the others under the current work environment.

With enough time, we can do our jobs more carefully and we have better communication. Actually it is very important for nurses to improve the quality of health care. I have been working in high risk environments with fear. It is a pity to be without a good environment to ensure normal work under this system. (...)It is a pity that so many nurses are leaving. Several dozen nurses enter the hospital, but several dozen nurses quit jobs each year. This gap will never be filled. (Yang)

Perceiving the high risk in clinical practice environment, many participants did not think that they could change the current situation by their individual efforts.

I have thought about influencing my colleagues and also my ideas could be accepted by the leaders. In fact, the individual energy is limited. ...The current system couldn't ensure a standard and safe work environment. I gave up since I could not change it. (Yang)

I really sympathise with the nurse who had the accident and it might unluckily happen to me. I could not avoid it in such a busy and unsafe

environment ...I could not change it, but at least I have capability to escape.
(Ting)

Perceiving the barrier of organizational risk management to patient safety, many nurses felt moral stress that their individual efforts could not change the stressful work environment to ensure the quality of their standard daily practice. The evidence has shown that when the work environment could not support nurses to ensure the quality and safety of patient care, the more capable nurses seem more likely to choose to leave nursing rather than stay in nursing for life, since they could not afford to fail in their principle professional accountability for the safety and quality of health care.

4. Failing to meet the expectations of patients

Chinese nurses were required to provide different standards of health service for different patients. The majority of participants expressed unresolved dilemmas of failing to meet the expectations of patients which further contributed to their leaving nursing practice.

Yang felt it difficult to meet the needs of the patients who paid more money for the VIP service in a general unit, which is currently encouraged by the hospital administrators.

The health care expenditure is so high. Sometimes if the patients' family are well off, they would like to pay more for better service, so we were asked to give more time and care for their satisfaction, but we still need to care for so many other patients. Most patients' requirements could not be met well. If the patients were unsatisfied with the health care, they dare not complain to the doctors since it might negatively influence their treatment, then they blame us, but we could not defend ourselves or enter into open conflict with them, since we need to carry out the treatment and ensure they recover smoothly. Then the nurse would be hurt deeply in her heart by some difficult patients, which is painful. I had suffered... The hospital managers did not protect me even if the conflict was caused by a hospital regulation. They still asked me to make apologies to the patient. I told myself that I would never ever make such an apology again in my life (She spoke with tears.) (Yang)

Yang was particularly sad once when she could not meet a specific requirement from the VIP patients' family but was required to apologise despite her innocence. With rapid economic development in society, some people paid more in order to get a higher quality of health service, which has been encouraged in all the hospitals. Currently all Grade three hospitals have provided special health care for the "VIPs", which mainly focuses on rich people who can afford to pay more for better service or important people in high social positions who have the power to influence the operation of the hospitals. Once conflicts happened, the individual nurses who directly deal with patients' demands became easy targets as the scapegoats of the hospital in order to comfort the patients' dissatisfaction. Participants not only felt frustrated in treating the patients differently but also felt disappointed that they must take the patients' blame without the hospital administrators' understanding and support in such a demanding work environment.

Fei has worked closely with the "VIPs" after she left clinical care. She opened an diagnosis room in the VIP department to accept my interview, so I had a chance to visit the luxury area which was decorated with comfortable antique furniture.

There are more nurses in the VIP department than other units with a lower workload. Although I do not work here as a nurse now, one of my main duties is to accompany some VIP governors to see the medical experts. Usually they did not have serious problems and just needed some physical examination or expert suggestions. There seems to be a better communication with these VIP patients. (Fei 1029)

Comparing the "VIPs", Fei mentioned some patients as "difficult patients".

Fei: It is fine for me to practise in nursing, but I felt it difficult to deal with the relationship with patients. Some difficult patients you might causally meet.

Zhu: What did you mean by difficult patients?

Fei: ... (0.3)

Zhu: (Smile) could you give me any example of such patients?

Fei: ... (0.1) There are some elderly patients in the Endocrinological unit, who need to come back to get the blood glucose test strips after being discharged. The patient came back at night at the time we told him. But the nurse on night shift could not find it, so the patient got annoyed (mock the angry voice of the patient): "You did not get it but let me come to the hospital. "

The comparison of the quality of care between the “VIPs” and the “difficult” patients was significant. In the same public hospital, on one side, the VIP patients enjoyed their priority with preferential arrangements. Under an obvious nursing shortage, offering more nurses for the “VIP” service seems to be regarded by the hospital administrators as an effective way to generate profits from rich people or to exchange power with the people who have authority over hospital administration. On the other hand, the VIP service has increased the nursing shortage and reduced the general patients’ satisfaction as they had to endure inconvenience and a less qualified health service.

Rao pointed out that the “difficult” patients might protect their rights, while the “easy” patients’ rights might be neglected under the current health care environment.

The staff directly say that this patient is difficult to deal with. The picky patients usually get better care, because the staff want to prevent them from making trouble. If this patient is easy to deal with, maybe he can become the target of medicine abuse. I think so. Although I am always nice to other people, having worked as a nurse in the hospital, I am afraid that we have no way to stop the improper manners. ... It is true. In dealing with the adverse events within the hospital, the more aggressive the behaviour the more compensation the hospital would give. (Rao).

Rao expressed her certain understanding that some Chinese patients believe that their rights could not be protected within the hospital if they keep quiet; they became aggressive towards the staff when they were dissatisfied with the quality of care in the Grade three hospitals or they did not trust the health staff. The view that the more obedient patients might be neglected was echoed by many participants. The majority of participants sympathized with the patients' difficult situation based on their nursing perspective. When the hospitals tend to cover up the adverse events before the patients know of them, it is hardly surprising that the currently tense relationship between the public and hospitals has caused actual violence in clinics due to the lack of mutual trust, and this has been frequently reported by the media. Xue witnessed violence frequently happening in the emergency department, and worried that she might encounter violence if she continued her nursing practice.

Some people become crazy after drinking alcohol too much. It is terrible to deal with them. But the most terrible case was that a patient died of

myocardial infarction because of inappropriate treatment by doctors. The problem was not discovered in time. Later he was in great pain and he died before being noticed. He was very young, and his family members came to the hospital and beat doctors and nurses. It is terrible! ...When a doctor was seeing a patient, a lady who was waiting to see the doctor kept on asking the doctor to hurry up. She kicked the doctor on the waist, causing renal haemorrhage of the doctor. ...The most regrettable thing was that the medical director and hospital did not 'stand up' to support the doctor. The doctor was very sad when he was blamed for the incident. When a patient asked a senior nurse about a medical issue, perhaps there was lack of effective communication, the patient beat the nurse which damaged her face. The nurse felt angry and called the security department for help. She felt bitterly disappointed as the hospital did not attempt to protect her. In the year of my leaving, sometimes I told myself if patients beat me I would take off my uniform and fight back. The hospital did not protect and compensate nurses whenever nurses were unreasonably beaten by patients. If there is no guarantee for personal safety, how can we work with a peaceful mind? (Xue)

Although only Xue directly mentioned the clinical violence relevant to her leaving, it is not rare that some nurses left since they could not accept being a scapegoat in clinical violence without the hospital's proper support. Assault and violence in clinics towards medical and nursing staff frequently happened in Chinese hospitals nationwide. Many leavers felt wronged that even though they worked hard for patients, they still had to take the blame from the patients.

For economic reasons, the hospitals work hard to attract more patients. One more patient means more money for the hospital. We are very sad working on this hard job, since we don't deserve to have the bad reputation sometimes. (Chen)

All the blame is put on nurses. The patients dare not be rude to the doctors. We have become the punchbags for people to release their anger on. In this occupation, we have to endure complaints and pressure. We are actually very depressed. (Ling)

The nurse is a necessary mediator. It is actually very difficult to play this role. As a nurse, you don't have the power to make decisions, but you may have to take all the responsibilities as a mediator. You can become very upset. (Ting)

Chinese patients have been regarded as customers by the hospital administrators, since they pay increasing amounts of money for the health service. Most of the participants could understand that the Chinese public are generally dissatisfied about

the current high cost of health care and the patients expected nurses to provide safe and quality health care and service.

However, some less experienced nurses tend to passively follow the requirements of the hospitals. As a new nurse, Yan described a “difficult patient” in her practice.

A patient needed to continue the intravenous drip, but the fee information notes arrived at the bedside saying that his account had no money. The hospital policy is that he only could continue the treatment if he had enough money, so the IV was taken off. After he put more money into his account, then I gave the injection to him again. The patient felt very dissatisfied and accused me, asking why I could not let him finish the IV then he would have gone to pay for it. It was useless to explain about the hospital policy, but I have no way of changing it. (Yan)

As a young nurse, Yan felt that she had to follow the hospital requirement as the priority rather than fighting to protect the right of patients, which made the patients angry towards her. While a few participants who left nursing sooner than 1 year carried out the task without concern for the needs of patients by following the organizational rule without consideration for the quality of health care, most participants thought that they used to take good care of patients, but still felt an increasing pressure under the wider, intense health care environment within the hospital.

Patients said that I was the best nurse there. Surely, nurses could improve the patients’ satisfaction, but patients did not have the right to make decisions for us, and we could not expect them to clearly understand the importance of nursing. Nowadays, the relationship between staff and patients and their relatives has become tense. (Ling)

I have good communication with patients. After all, there are very few unreasonable patients. The tense relationship was caused by the unsettled society. On one side, everything is driven by a financial incentive, such as over-treatment and over-operation. On the other side, there is a lack of harmony in the wider social environment. The media seems to have misled the public opinion. The media like to find something wrong with us. (Chun)

These participants’ hard work was obviously well trusted and they satisfied the patients they directly worked with. Actually the nursing workforce became very important coordinators between the patients and the health service system within the hospital through their nursing criteria. Their contribution has reduced certain levels

of tension in relationships between the patients and the doctors in the hospital. Many participants thought that it was inevitable that the social status of nurses would go down. It is understandable that some participants felt disappointed that they could not get respect from their patients although they worked hard.

A mum was sick in the hospital and her daughter visited her. She educated her daughter: "If you do not study hard, when you grow up you will be a nurse." I felt bitterly disappointed that society has such a view of nurses. ...I determined to be a doctor. (Yuan)

The negative attitude of patients towards nurses has been perceived by many participants. Nurses were generally regarded as low level workers without patients' understanding and respect. They felt that patients did not respect their hard work, by which they concluded that the social status of nurses has declined in recent years. The majority of participants tend to blame themselves or colleagues when the quality of health care was compromised.

If I were the patient, I would have more complaints, because patients are usually submissive without knowing it, but I knew the system well as a nurse. There are too many troubles for patients within the system, which we could do much better. Sometimes I saw some nurses just muddling through patients' requirements. Although they have some free time they did not communicate with patients but sat there chatting with each other. (Xue)

Patients who do not know about the health system accept the services without a clear awareness of the quality of care. I do think there are some problems with the quality of nurses. Many nurses are passive in work. They don't have an active attitude for patients. I also might not have such strong awareness, but I thought I was taking my responsibility seriously when I worked as a nurse. I did all jobs which should be done for patients and did not omit my duties. Some nurses did parts of the work but ignored some of them. Others didn't know whether you have done it or not, especially when you work alone and it is difficult to finish everything well. Therefore, some problems are transferred and have an effect on patients now. (Ling)

Under the reality of nursing shortage, the staff had to focus on finishing the task rather than becoming concerned with individual patients' needs through patient-centred holistic care. Although participants generally felt that patients did not value nurses' social status, the majority of them expressed that they could understand the situation of the patients within the hospital based on a nursing perspective, because some nurses did not take good care of patients. They pointed out that a passive work

attitude among the current nursing workforce has resulted in patients' suffering. The participants generally lost a sense of being proud as a nurse.

5. Summary of 3rd data chapter

The data indicates that all participants lost confidence in the safety and quality of health care. Perception of the high risk of clinical practice has negatively impacted on many participants' faith in nursing, since it goes against their expectations of taking professional accountability for the safety and quality of care by being a good nurse. While the inexperienced nurses rarely comment on the safety issues, but concentrated on learning the organizational rule as their standard practice in order to protect themselves, the experienced nurses found that they could not change the high risk work environment by their individual efforts without proper risk management in the organization under a blame culture. Although the hospital adopted different strategies to improve the safety and quality of health care, the participants thought that patients' rights may be compromised due to the organizational barriers. The significant contribution of nurses to the safety and quality of health care seemed to be ignored by the doctors and hospital administrators, since nurses are only required to keep quiet and work hard under the shortage of nurses. The evidence demonstrated that there was a lack of sufficient educational, organizational and political supports for the individual Chinese nurses to take professional accountability for the patients' safety and quality. Meanwhile, the financial drive orientation has put nurses in the difficult position of having to meet the patients' expectations and still make the profit demanded by the hospitals. They felt that they failed to meet the expectations of patients although they were working hard, which has caused nurses' ethical dilemmas and emotional suffering. Leaving nursing was regarded as a way for participants to escape from the high risk and low quality of health care work environment.

Chapter 6 Conflict with doctors

1. Introduction

This chapter is concerned with the nurses' description of how they perceived the imbalance of power between nurses and doctors. The following two themes which emerged from the data will illustrate that nurses' conflicts with doctors were based on their different financial and social rewards, professional autonomy and contribution.

- Comparing rewards with doctors
- Struggling with medical dominance

Nurses expect their medical colleagues to understand their professional contribution, but the input of nurses is easily dismissed by doctors. The majority of participants felt frustrated when they had to face covert conflict with the doctors in their clinical practice without organizational support. Ting expressed the wishes of many of participants.

If doctors could appreciate our contributions, at least we could have a good micro environment and I would feel happy and would be glad to continue work every day. (Ting)

2. Comparing rewards with doctors

The participants, particularly those who entered their nursing career before 2000, expressed similar feelings that “the relationship between doctors and nurses was not as good as before”. The frequent conflicts mentioned by participants are caused by their dramatically changed economic status.

Ting: ...The conflict between nurses and doctors caused us suffering.

Zhu: How do you think the current relationship is between nurses and doctors?

Ting: Nowadays it is very serious. Previously all staff members were fairly equal. There was no “grey income”, and no kickbacks from the pharmaceutical companies. The reform of the hospital has caused serious conflicts of interest. All hospitals claimed that the distribution of bonuses should be according to the work done. Actually the first distribution of bonuses to each unit is decided by the hospital managers and medical directors. The redistribution of bonuses within units depends on negotiation between the medical director and the head nurse. ...If they have a good relationship, it would keep a certain balance. If the director is a dominating person, the doctors’ bonuses would be twice or triple the nurses’ share...The doctors thought that the patients were attracted by their medical expertise. “If we did not get the patients, who are you nursing for, who will you have to nurse?”

Zhu: The gap between bonuses is different...]

Ting: [Actually the unequal bonus cannot create such a big difference in the income of doctors and nurses, but the kickbacks from pharmaceutical companies make the gap significant. They receive 5000 Yuan monthly income from the hospital, meanwhile they could get 10,000 or 20,000 Yuan by kickbacks from the company. Well, it is for profit... it is really ugly. Now, they do terrible things openly.

Ting used “ugly” and “terrible” to describe the unprofessional behaviour of doctors under the financial incentive. She supposed that I understood the sense of resentment as I was a nurse and she did not offer further explanation to me of why she criticised this behaviour by using these extremely negative words. I did not disrupt her by asking her questions for clarification at that time, because I felt she emotionally expressed what she believed. Such emotional comments are neither true nor false, but rather have effects which she considers to be relevant to her leaving. I found that the participants perceived me as an insider and it was a privilege for me to listen to their frank comments without being afraid to express their feelings. Without disruption and judgement, the interview then naturally follows as she further explained.

Ting: Our nurses are not foolish, why did the doctors give such prescriptions; why did they frequently change the antibiotics from day to day. We all knew why they did it. We are very clear about the work of doctors, and how they operated. However, the doctors started openly doing evil things: “What can you do to me even if you know why?”

Zhu: (Nod) only doctors could make the decision about the prescription.

Ting: "Medicine is not you nurses' business. It is my right. I took the risk and I got the money by myself. It is a fair deal." They did not care about your opinion, right? (She raised her voice)

Zhu: Sometimes, it is...]

Ting: [Then, the doctor, he was going to sleep after giving lots of prescriptions for the patients. He has made his money. Then the nurse had to give the intravenous medication to the patients one by one, even though she knew it was unnecessary. (Sighed) The nurses leave their position because there are too many imbalances. (Her voice slows down).

Ting declared that the imbalance of financial status between doctors and nurses pushed the nurses to leave. She regarded unnecessary treatment for patients, which was provided by doctors, as "evil". From the excerpt, what Ting means by the imbalances are not only limited to the financial rewards. The difficulty of challenging the authority of doctors who are over-prescribing seems to have brought an unconscious ethical dilemma for nurses, who could not control nursing practice for the patients' benefits based on their nursing knowledge. The dilemma caused by the unprofessional behaviour of medical staff has been reflected by many participants.

The doctors keep on using antibiotics whether there is an infection or not, before and after the operation. They often remember to give prescription but forget to stop using them. We checked the medicine after receiving the patients' complaints about the high bills. You would know how expensive the medicine is used. Then patients said: "I am all right now, why did I still use it?" We would encourage them: "You go and talk with the doctors by yourself." Then they went to ask the doctors. Sometimes, the doctors were very clear it was unnecessary and would stop them. (Yan)

The whole atmosphere is there. Patients would think that the doctor did not pay attention to their situation if they had not been given an IV. They came to the Grade three hospitals since they did not believe the lower grade hospital could help: "It could not be cured only by oral medicine. Otherwise we could just go home." In order to comfort them staying in the hospital...The doctors gave the IV. Also it is impossible to use only oral medicine in our unit, since the other units all gave 100% of IV. The hospital evaluates the unit according to how many medicines you used. It is a real problem. (Yang)

Yan implicitly encouraged patients to challenge the doctors' authority by themselves, when the patients initiated questioning of their treatment; while Yang commented on

the over treatment due to the external pressure in the current work environment. The evidence shows that the medical dominance has caused an ethical dilemma for nurses. As a way to avoid directly criticising doctors and remaining loyal to doctors as colleagues, they only blame the financial rewards which compromise the benefits of patients.

Yuan, who now works as a doctor, added the view from a doctor' perspective when I asked how different income between doctors and nurses is within the hospital.

Certainly a big difference, it is hard to say how much different since I have not compared it yet. Possibly some kickbacks exist, but I dare not receive them since I have a conscience. I will give medicine only if the patients need it. If the patients are well-off, I will choose more expensive medicine or the medicine imported from the West, because the expensive ones would be more effective. If the patients are poor, I will choose cheaper medicine and medicine made in China, which could save money for them. Recently the hospital began to control the medicine used, so the bonus may be higher when there is a higher proportion of treatment using advanced techniques or more equipment with less medicine. (Yuan)

Yuan avoided talking about the kickbacks from her position. It is understandable that she tried to defend doctors from the medical science perspective and emphasised her professional conscience and sympathy for patients. However, Yuan further confirmed that doctors decide the treatment plan according to the financial capability of patients and the criteria of the hospital's financial evaluation, which seems well accepted by Chinese doctors as normal practice. It is noteworthy that the resources expended on patients with insurance are about 3.5 times more on medicine and 1.6 times higher on a length of stay than those expended on uninsured patients, according to Dong's (2001-02) reports. This is not only because of the inequality of the health care system, but also because the profit incentive has a powerful effect on Chinese doctors' behaviour toward self-interest at the expense of patients (Hsiao 2008, Ma *et al* 2008).

While the commercial exchange has become an unspoken rule among the medical profession, many participants were hesitant to criticise the individual doctors. Some

participants felt the obligation to remain faithful to their medical colleagues, although they disapproved of the doctors' professional judgement.

I must be fair to say that our director is an academic person of integrity. Working in this environment, it is not realistic that she would not become involved in any commercial affairs. I respect her, since she works hard. Certainly, she protects the benefits of doctors first. (Yang)

Participants generally felt it difficult to challenge medical dominance, while the implicit rule that kickbacks form part of doctors' income within the hospital is accepted as normal. Many of them shifted their anger towards the medical sales representatives rather than the doctors.

When they came to the hospital, the medicine became more expensive. They would very often invite doctors to go out for a party or a dinner. Sometimes, they came to meet the doctors on night shift and brought gifts or dessert for them. One night, a medical sales representative expressed her sympathy for my busy workload when she was waiting for the doctor. I thought that the suffering was all because of their wrong-doing. (Yan)

It was a lack of autonomy that led clinical nurses to raise the covert conflicts with individual doctors based on realistic workload and ethical dilemmas. The majority of participants complained that they could not control their workload when doctors gave over prescription for extra payment. Xia linked the impossible workload to her leaving.

I was scared that I could not cope with so many intravenous infusions during the night shift. Especially when I encountered some doctors who liked over-prescription. For example, for a common cold with a slight fever, usually the oral medicine should be fine, but the doctors would give two or three medicines by IV, such as antibiotics and Vitamin C. They just want to make more money! Sometimes I got very angry... so many patients with unnecessary IV at midnight...I was under pressure in the night shifts since I might lose control of carrying out all of tasks. (Xia)

The profit-driven hospital management has resulted in a heavier workload within strictly limited nursing staffing, which has dramatically increased nurses' workloads. As an experienced nurse, Xue got angry since she could not control her work to a reasonable workload and had to carry out the unnecessary orders of doctors, which has resulted in her eventually leaving nursing.

The majority of clinical nurses are usually excluded as business targets; therefore they could stand up for the benefits of patients rather than go along with the medical sales representative for personal benefit. A few senior nurses and head nurses recently have been targeted as potential customers by some companies.

The Company would provide 80 Yuan kick-back when we used one tube of peripherally inserted central catheter (PICC). My head nurse asked me whether we accepted it or not. I said no. Although we had the right to order the tube, I would keep myself free and out of their financial control. If we received the money, we could not protect the benefit of patients. However, as the company provided shopping cards or gifts for all staff we could not refuse. Anyway I did not accept the 80 Yuan, so I could speak for patients by choosing the best quality of tube...The tube cost more than 1000 Yuan. If I failed, the patients would waste money, so I always tried my best and wanted to be successful at the first attempt. (Qun)

Nurses like Qun want to keep themselves free from commercial exchanges and protect the benefit of patients. Without institutional support, she could only protect patients through her direct sympathetic care. As a medical consultant working for an international company, Bo pointed out that the company adjusted their commercial strategies in order to reduce nurses' passive resistance and increase cooperation within the hospitals, such as providing some money back to the nursing managers or offering a small amount of funding as welfare for the whole nursing staff, which even Qun could not refuse as an individual. This practice further silences nurses from expressing their views and avoids an open discussion about the ethical dilemma under the financial incentives in the hospital.

Meanwhile some nurses who left had been highly valued as a precious, potential resource to opening the market in the hospitals by the national or international pharmaceutical companies. The social cost of losing a nurse has caused further negative impact on the cost-efficiency of health care and the morale of nurses. The consequences were confirmed in a later interview with Ting.

Some newspapers learn that a few doctors never prescribe unnecessary medicine for patients. It may be true, since they may believe in Buddhism and have particular conscience concern for patients, but it is very rare. Why should doctors refuse to get money if the policy and system allow them to do so? Doctors are working hard too, but at least they could find a balance

between prescribing medicine and making money. Doctors welcomed the medical sale representatives as they brought money. ...I would say that nurses were silly if they despised the job of medical sale representatives and dared not to get the benefits they could. (Ting)

Although Ting expresses resentment at what she was doing when she was a nurse, she currently works as a consultant for a milk company and as a sales representative for pharmaceutical companies. Ting admitted that she did not feel her nursing knowledge was valued by the hospital but was highly valued by the companies who gave it high financial reward. It was ironic that Ting thought nurses who insisted on highly value for the morality of nursing with low reward and respect were silly. The good morality of nursing was unexpectedly undervalued by the leavers who are subsequently successfully involved in the medical business for financial reward. Many participants did not believe that the benefits of patients could be achieved by nurses' efforts within the health care system.

The hospital only required our nurses to improve the quality of service. Why could they not ask doctors to give less medicine by IV and get fewer kickbacks, it would be much better for patients. (Xue)

Xue's complaint represented many other nurses' views. By comparing rewards with the doctors, the evidence provided by nurses partly explains why the expenditure of the health service continued to increase and has become the second priority issue, after the safety issues, which faced the current Chinese health care system, as the introduction chapter indicates.

3. Struggling with medical dominance

When medical professionalism collapsed due to the financial incentives, many nurses felt powerless to change the unreasonably high cost of health care under medical dominance without organizational support.

Firstly, nursing autonomy has not been encouraged under the medical dominance in the Chinese health care system.

Nowadays nursing education encourages nursing autonomy, but I don't have autonomy within the hospital. Is it a contradictory idea? ...The more value is placed on nursing autonomy the more the nurse in conflict devalues herself. There is no space for your capability, so why do I stay in this field. (Ting)

Another participant questioned the first nursing law as follows:

Nursing Law demands that nurses should report an emergency case to the doctors first. How did you do it if the events happened in your night shifts? There is only myself available, if I call the doctor first, the patients would lose the chance to be rescued. I would let the patients' relative call the doctors, while I do not know what I could do if there was no relative beside them. Nursing law also demands that nurses should detect and stop mistakes made by the doctors. It requires us to be competent in everything and even more knowledgeable than the doctors ...Actually, nurses are very tired. (Yan)

Nurses were expected to take responsibility for stopping clinical mistakes but they were limited in making clinical decisions. From several participants' view, the first Nursing Law seems to be less practical in the real clinical practice situation. Xue thought that doctors did not appreciate nurses' contribution although nurses stop doctors' mistakes to protect patients' safety.

There are so many errors occurring, but when nurses asked the doctors to correct them, some doctors said that nurses just focus on small things, without saying "sorry" or "thanks". (Xue)

Doctors evaluate nurses according to their own standards.

The doctors hope to work together with competent nurses. If you know everything, doctors would think that you are good nurse, and then they can be relaxed when working with you. It is difficult for nurses. When a patient's situation has changed during the night shifts, if you could directly deal with it and did not wake up the doctors, this would be approved of, but then if I wake them up for intervention, then the doctor would complain that I was not a good nurse. (Chun)

Many participants found it difficult to meet the "good nurse" criteria from the doctors' perspective. On the one hand, the capable nurse might exceed nursing responsibilities without an awareness of their professional boundary, which means they are then not only over-burdened, but also may increase patients' risk through their practice. On the other hand, the nurses who are less confident or less aware of the risk to patients would hesitate to call for doctors on time for the proper medical intervention, since they are afraid of being judged as "bad nurse" by doctors.

While from doctors' perspective, Yuan thought that nurses' attitudes towards doctors were a little bit harsh.

Doctors generally have a good personality since they normally tolerate nurses' blame. Some doctors adapted their treatment in order to make nursing work more convenient and avoid the conflict with nurses. (Yuan)

Xia thought that the tense doctor-nurse relationship is because there was a lack of effective communication.

The senior doctors believed that nurses should listen to them, because nurses have very limited knowledge. Some doctors even tried to shake off their responsibilities which made the contradiction between doctors and nurses more intense. Actually, as professionals in this area, we knew the truth well.(...)If the experienced nurses can remind the doctor in a nice way, he would be happy to accept. I have been in such situations before. Actually I wanted to tell him very nicely, but I was too busy and I also expected that he would accept my advice. Maybe the doctor was also busy. I became angry when I found out that he ignored the advice and I could not do my work properly. Later I phoned the doctor and asked him why he did not do his work in time. The doctors are also sensitive about their reputation, so he was not happy because a small nurse dared to order a big doctor to do this and that. After similar cases happened several times, he may have a bad impression of the nurse: she is not friendly and not easy to talk to (smile). This kind of doctor is not rare in the hospital. (Xia)

The evidence reveals that the criteria in assessing a nurse as "good" or "bad" from a doctor's perspective depends on their personality rather than professional attitudes and contribution. Most doctors regarded nurses as subordinates, who should obey doctors' orders, and if there is something which needs to be reported, their attitudes and behaviours should be gentle and nice, which is the most important factor for effective communication as perceived by the participants. As the data indicate, too busy an environment may make the gentle attitude become impossible. Bo felt powerless to work well under the medical dominance.

It was very difficult for the nurses to communicate with the doctors. The relationships between the head nurse and the medical director became worse. Although the head nurse did not like the director, I admired him and he thought I was the best nurse in the unit. When there is an inharmonious atmosphere within the unit, which directly influenced the patients' safety. I normally kept a good relationship with doctors, but one day I did quarrel with one (a young doctor). After I had the conflict with him I felt extremely

sad. We both were almost the same age and level of education (bachelors' degrees), but why was the gap between a doctor and a nurse so great. I thought that I should not work as a nurse any more, and I felt that I was not suitable to be a nurse. (Bo)

Bo perceived that the conflicts between doctors and nurses have created an insecure environment for patients in the unit, but without effective managerial communication and support, the conflicts prevented effective resolution of the problems to the benefit of patients at the individual level. She felt particularly frustrated after she could not avoid an open quarrel with a young doctor, which forced her eventually to go for another career in order to leave this subordinate position in conflict with the dominance of medical staff. When nurses withdraw from their professional judgement and responsibilities, the patients' right and benefits would be compromised.

Ting suggested that doctors and nurses need a mutual understanding and effective communication from their initial education.

Just as we discussed, before graduating from the nursing school, nurses should learn how to communicate not only with patients but also with the doctors. They should also learn how to communicate with us. However the doctors do not have education in this respect and neither do nurses. Therefore, we have the bloody painful conflict experiences in practice....I would say; some senior doctors would respect nurses more than the juniors. (Ting)

Nursing education mainly follows the direction of medical science, while different levels of medical education did not discuss any cooperative relationship with nursing, although they must work together in their career. Therefore, for most nurses, to avoid openly discussing the conflicts with doctors has become their priority in clinical practice. However, without effective legislation to ensure doctors' professional practice, some doctors might not change their behaviour even though their unprofessional practices were known to the hospital administrators. These were evidenced by several participants.

Several doctors often received a fine by the hospital medicine control panel, but they continue to do it, because they got more money from the company than the fine. (Fei)

Meanwhile lacking confidence to challenge the medical dominance might be caused by an imbalance of autonomy based on their professional knowledge and consciousness.

There is no position for nurses to raise their voice in the hospital. If the nurse said that the doctors should not use the medicine, then if anything happened to the patients, whatever the reasons, it would be the nurse's responsibility. (Ting)

Nowadays the nursing office often emphasizes that we should not do 'good deeds'. It will put the nurse in a difficult situation without enforcing a rule. You must call the doctor if anything happened to the patients. I guess no one dares to do the same thing now. Even the oral advice of doctors is not allowed. We all need clear awareness of self-protection. (Chun)

Nurses are generally worried about being involved in trouble. Without nursing managers' support, individual nurses withdraw from their autonomy even though they have the capability of acting autonomously. When nurses were afraid to damage their personal relationship or work relationship with doctors by standing for nursing autonomy, their willingness to protect the rights of patients became impossible.

4. Summary of the 4th data chapter

The imbalance of financial and social rewards between nurses and doctors was not only caused by a great gap in the financial rewards between doctors and nurses without a transparent financial reward system, but also has resulted in ethical dilemmas for nurses who had to implement unprofessional medical orders with patients. However, nurses' professional contributions and values were usually ignored by the medical profession without organizational support. Nurses rarely have space and autonomy to openly discuss the covert conflict by challenging medical dominance. Under the imbalance of power relationship between doctors and nurses, some nurses had to continue to keep quiet without raising nursing autonomy. Keeping the covert conflict with doctors closed within the hospitals has resulted in the nurses who are more aware of nursing autonomy under medical dominance deciding to leave the powerless status of being a clinical nurse. There is a lack of educational, organizational and political support to rethink how the two professions

might resolve their conflict and help them to work together for the quality, safety and cost efficiency of health care under the current Chinese health care system, in which it is very important to retain nurses in clinical care without suffering frustration.

Chapter 7 Lack of management support

1. Introduction

When participants were at the hesitant stage: “Should I stay or should I go?” They expected their intention of staying could be supported by the nursing managers. However, the participants expressed an overall disappointment. There was a lack of managerial support to maintain nurses who intended to stay in the ideal workplace, which were illustrated by the following three themes in this chapter:

- Emphasising nurses as replaceable labour
- Losing enthusiasm in promotion
- Struggling to meet career progress

2. Emphasising nurses as replaceable labour

Participants expected their individual effort and professional contribution would be valued by the nursing managers.

Appreciation about my work from the nursing managers could reduce my intention to leave. (Yun)

Yun typified the view of many who were willing to contribute their efforts in a nursing career and expected to be respected as a valuable member of the organization by their nursing managers. The acknowledgment of the nurses’ value and contribution from nursing managers has a significant impact on their nursing career decisions. Qun withdrew her first intention of resignation while the vice director appreciated her hard work.

I went to the nursing office to deliver my resignation. The director of nursing was unavailable, and the vice director of nursing refused to accept it. She said: “I will agree with some nurses resigning their job immediately because I don’t think they are suitable for nursing, but you are outstanding from the others in every aspect .(...) To tell the truth, many people want to join our hospital. The world will not stop turning without you. It is a loss for the hospital and yourself if you insist on leaving. You will miss the days working

as a nurse.” Maybe she has forgotten what she said, but I still remember the last sentence which moved me. (...)Er, that was the first time somebody knew I was doing a good job. At least somebody appreciated my efforts. I withdrew my resignation immediately. (Qun)

Qun enjoyed her 16 years’ work experience in nursing practice. As the team leader, she was quite confident in dealing with the most difficult cases in PICC and IV and was happy to offer her expertise to colleagues at unit and hospital level. The head nurse and the vice director acknowledged her excellent work performance which convinced her to stay for the sake of nursing. The experience highlights Qun’s unwillingness to give up her career in nursing but she expected to gain nursing expertise development in PICC. Therefore, Qun had to communicate with the director of nursing who was also the team leader of PICC, since she had the dominant power in nursing personnel management. By directly handing in the resignation letter to the director of nursing after two months, Qun eventually got a chance to meet her. The following extract illustrates that moment.

My colleagues said that my resignation sounds like a job application. (...) I gave the letter to the director of nursing in her office. In a very cold voice, she said: “Just put it here”. ... (0.2) Then I did not know what I could say. I felt lost. She just accepted it without a word. ... (0.3) I had made good preparations. If she would talk with me, I wanted to ask her whether I would have the opportunity work in the PICC unit as it was in the planning stage.(...)I expected that she would comfort me saying that I might have chance to work in the PICC even if I needed to continue work in the chemotherapy unit. (Qun)

Qun laughed off her resignation as “a job application” from her colleagues’ perspective. The face-to-face conversation with the nursing director was the first one she ever got after so many years working in the hospital. From what she explained, the resignation was intended as a strategy to seek a stay, which was based on her assumption that the leader would appreciate her expertise and professional reputation. However, she did not have a chance to start effective communication with the director regarding her actual expectation of career development in nursing. In the absence of any attempt to retain her, Qun thought that she had to leave, but she still hoped that one day she might go back to the hospital and contribute her expertise in nursing. However, she realized that it was impossible for her to return to the hospital.

After three months, my head nurse invited me with her to attend a PICC membership party in order to thank me for my contribution in training the PICC staff before I left. I was so excited to accept it as an honour. I met the director of nursing at the party. She said that I must be very happy to be a boss now. I told her that I felt I lost my value as a nurse after leaving, although I have a successful family business. And she said that I could come back if I felt nursing was so good. Suddenly the colleagues surrounding the table became very quiet as many of them did not know I had quit. I said that I would like to do the PICC and regarded nursing as a career for my life. She did not answer me... (0.3) (Qun)

A long pause released her strong sense of loss. The negative reaction by the director of nursing towards her enthusiasm for nursing has been interpreted as a final end of her dream to remain in nursing. Qun commented on her leaving:

Other nurses who left nursing might feel a release; but you know; I left without choice. I lost my sense of value of being a nurse. I did not want to be an ordinary nurse forever. (...) Many excellent nurses did not work efficiently within the hospital. I absolutely felt that I had no bright future as a nurse. Sometimes I thought that if I had to stay in nursing for life as other colleagues, I might still work as a happy nurse. You know that you still do something relevant to nursing after you left, but I could not. (Qun)

Qun felt hopeless that she must abandon her nursing career because the director of nursing did not have any intention to ask her to stay or to return. From the managers' perspective, Qun must be happy to be a boss, but Qun has a sense of regret that her good family financial circumstances gave her more options for career choices but could not help her to stay in nursing and be valued for being a nurse. However, although some participants were asked to stay when they handed in their resignation, they expressed a similar feeling to Qun, that the nursing directors did not really appreciate what they have contributed as experienced nurses and did not provide feasible strategies to retain them.

Because her position determined that she should have asked me to stay. Actually they did not care to lose one nurse; there are plenty of young nurses available to replace us. (Yun)

Xue even experienced an unpleasant conversation with the nursing director. The harsh manner that the nursing managers showed towards her accelerated her decision to leave. Xue was asked to give an explanation for her sick leave request in the

nursing office, after the head nurse refused to let Xue move from the E&T department.

I was hesitating whether to quit the job or not at that moment. The head nurse was angry and accused me of not being grateful to her. The director of nursing just criticised me about the sick leave. (...)I wondered how I could continue to work in such a work environment. Then I asked her to accept my resignation immediately. I was disappointed that the hospital did not care about our leaving. It is a loss for hospitals, but they did not care about the cost in recruiting and training new nurses which needs time, money and energy. It is not good for patients. On the contrary, they may think that they can save some money by recruiting nurses with a new contract, right? And the new nurses are more obedient. They will do whatever the nursing managers asked them to do. The senior nurses have their own ideas in practice and they don't always agree with the leaders. (Xue)

After Xue was refused the opportunity to change practice units, she asked for sick leave since she was still hesitant to give up the job working in the hospital as the privilege of health care for her family. Xue understood that the managers regarded nurses as easily replaceable labour and did not have a commitment to keeping the experienced nurses. However, while the nursing managers forced her to be obedient to their authority and ignored that experienced nurses require respect for their professional value and autonomy, Xue was not prepared to accept the disrespectful manner of the nursing managers and decided to give up her intention to stay.

Several participants left their jobs without contacting the nursing office.

My leaving is not important to the nursing office. They did not care. My resignation was directly processed by the personnel department. (Yan)

Nobody bothered to talk to me. Not really. Maybe, because I was not an outstanding member of staff, I don't think it was necessary to do so. Firstly, the director of nursing did not think that my leaving could bring any trouble to her, such as influencing the morale of the nurses. Secondly, she would not change the present management model because of my leaving. In addition, I wanted to quit the job not because I had made mistakes, but wanted to quit purely because of my personal choice. Therefore, there is no problem I could cause to the hospital. (Ting)

Ting and Yan worked in their hospitals for more than ten years and for one year respectively, but their nursing office did not have any desire to meet them before

they quit. Their experiences confirmed the popular view among nursing workforce management that individual nurses' leaving is not a problem for the hospital, but a problem for the individuals themselves.

Gao was determined to leave nursing after the director refused to meet her, when she was suffering serious back pain and expected that the director of nursing would help her to change to a suitable workplace in the hospital.

One day my back was so painful that I had to lie on the floor. ...I took one day off and was waiting to see the director of nursing in the hospital. She was very cold towards me on the phone: 'Back pain? There are too many nurses who have back pain.' She refused to see me and did not answer my phone again from the morning until the afternoon. I was much wronged. From her position, I understood she was tired of dealing with similar requests. But she cannot treat me in this way. I would feel much better if she answered me like the previous director of nursing. In that case, she would say: "I knew that you persisted in your duty although you had back pain." She did not care about nurses and she did not appreciate my merits as a valuable member of staff. I was determined that I must quit grandly, in order to let her know that my leaving was a loss for the hospital. (Gao)

Although the previous director's consolation delayed her leaving, Gao was angry that the nursing leader not only failed to recognize her contribution with more than ten years' service in the hospital, but also did not have a humanistic attitude to staff with health problems. The nurses who had health problems were generally regarded by nursing managers as a burden, as Ling commented.

I have witnessed so many excellent nurses who don't have a good outcome once their health deteriorates. The hospital said everyone should compete for their positions. No head nurse will choose you if you are not healthy. It has nothing to do with good skills and experience. The good nurse needs to be strong enough physically. (Ling)

The nursing managerial attitude towards the health of staff has a negative impact on a stable nursing workforce. As replaceable labour, voluntary leaving is regarded more as a negative event for the individual nurses, particularly for the staff with health problems, who are regarded as a burden released from the hospital. However, Gao determined to prove that her leaving was the hospital's loss. What Gao meant

when she said that she “quit grandly” was that she proved she was capable by becoming a lawyer after leaving.

It seems I became famous in the hospital after leaving. When I went back to the hospital sometimes, even the young nurses who I did not know treated me as a heroine. They told me that the director of nursing warned them during the hospital-level meeting: “You must work hard unless you are capable enough to become a lawyer, like Gao”. (Gao)

It was ironic that the individual leaver’s effort was used by the director of nursing to undermine the capability of the stayers. The managerial view, that nurses had to stay because they lacked capability or power to leave nursing practice, inevitably had a negative impact on the morale of the current nursing workforce. The individual leavers’ effort does not appear to stop the situation of more nurses experiencing a greater-than-ever indifference from the nursing manager. While the participants who left clinical care and entered successfully into a new career were regarded as models for their colleagues, and encouraged the capable nurses by empowering them to leave.

3.Losing enthusiasm in promotion

Only one of participants said that the director of nursing had provided an offer for her to stay when she decided to leave.

The director told me that nowadays the hospital did not control my leaving, but she still felt pity that I insisted on leaving. She said that she had a plan to transfer me to the ophthalmology unit since the head nurse will retire next year. I don’t know if what she said was true or not. At least she showed some desire to keep me. Later the director told me that I had a chance to continue my postgraduate study in the University with the hospital’s support, but I had decided to leave before I knew that information. I did not change my mind. (Bo)

From Bo’s description, the director’s offered her the possible chance for promotion and career development, which was exactly what she originally expected of being a nurse, but she still chose to leave. It seems that Bo no longer had any enthusiasm to be promoted, which conflicted with her original expectation in her nursing career.

To be honest, I had an ambition to be promoted as head nurse, so I took all opportunities to do the job and take good care of the patients as best as I could. We did not have many chances to contact the director. When the director of nursing came, I felt particularly nervous. If something I did was not good enough, she would have a bad impression of me. (Bo)

Bo expected to be promoted as a head nurse in the beginning as an ambitious nurse. In order to get promotion, Bo made great efforts in the workplace and also tried to establish a good work relationship with nursing managers, which seemed to cause her internal conflict between the roles of obedience as subordinates and autonomy as professional nurses. Bo eventually got a chance to work as the secretary in the nursing office, which was similar to Rao. They both interpreted the chance to work closely with the director of nursing as a precious opportunity to be promoted.

Before I was recommended to work there, two nurses in this position were very good at writing articles and had bachelors' degrees. They were young, beautiful and very suitable to work as secretaries in the nursing office. After they left the office, they were promoted to be head nurses and had good opportunities for further development. ...It was quite a happy time since I only needed to make tea, prepare articles or speeches for the director and plan the examinations for students and staff evaluations. (Bo)

In normal situations, an ordinary nurse doesn't have much contact with the director of nursing. She asked several bachelors' degree nurses to translate the English articles for her...I could feel that she appreciated my work and had a good impression of me. That was the first time I had contact with her and I started to have more communication with her. Later she let me take responsibility for clinical education as secretary in the nursing office. She gave that opportunity when she had an intention to promote you. (Rao)

These nurses who were selected to work as nursing office secretaries were usually capable and young nurses with bachelor degrees. It seems that they might be the future nursing leaders. However, both of them began to consider leaving nursing practice while they were working in the nursing office.

I began to think about leaving since I was worried about where I would go for the next stage. I did not want to be a clinical nurse again. ...Personally, I thought that it would be miserable if a nurse always worked as a clinical nurse and could not get a position as a manager, since you will be assigned to the logistics department when you were too old to give injections as your eyesight was not good enough. (Rao)

I thought about leaving at that time; one reason was that I might go back to the unit. Another reason was even though I could work in the nursing office for a longer time; there was nothing to be gained other than to be an office secretary and I would not develop well without clinical practice. (Bo)

Whatever the reasons, they were reluctant to be a clinical nurse or reluctant to go back to the unit. It seems that the office work disconnected them from clinical care, and their close work relationship did not provide professional space for them to openly discuss their career development with the director of nursing. Meanwhile, the opportunity for close observation of the position of the nursing office within the hospital management system negatively impacted on their enthusiasm for promotion, as Bo further explained.

When I was working in the nursing office, I found that the position of the nursing office is very low among the hospital administration offices. It is possible that some nursing managers do not protect the benefits of nurses, which I have encountered. Our director of nursing defends nurses, but she was the only representative of the nurses on the hospital administrators' conference. The nursing problems which were put forward by the director of nursing were generally not regarded as serious issues, since the doctors look down upon the nurses. The hospital president, the Committee of the Communist Party and officers of the hospital administration all support doctors but not nurses. Their contradiction was very intensely evident when these were in conflict. The hospital is managed somewhat like bureaucratic government. The most important aspect was that I felt, even if I could try my best to be a director of nursing one day, I could not change the low status of nurses. These efforts would be meaningless. (Bo)

It seems that the clearer the powerlessness of the top nursing managers was perceived by the participants, the more they undervalued the future of a nursing career and lost the ambition to be promoted. It could explain why Bo and Rao, despite having the most potential to be promoted as nursing leaders in the future, considered that leaving their career as nurses was a better choice than waiting for a promotion. Many other participants also acknowledged the powerless status of nursing directors in the hospital.

Our director certainly defended our nurses at the hospital administration conference, but nobody listened to her. (Rao)

In our hospital, several medical directors were in conflict with the director of nursing, since the director of nursing thought that she was responsible for the nursing human resource management within the hospital; but the

medical directors thought nursing staff arrangements in the units must have their agreement. (Gao)

When I asked the senior colleagues why the nursing office and head nurse did not explain the true situation to defend nurses in front of the president, they said that they never expected that would happen (Yan)

The presidents of the hospital and the medical directors have ultimate power in controlling the human resources within the units and at hospital levels. The powerless situation of nursing managers seemingly could not gain sympathy or support from the participants. One of the reasons was the terrible manners some nursing managers had towards their nursing staff as some participants expressed.

I just feel that they do not treat you as a human being. I wouldn't like to have a life being the director of nursing to humiliate others. (Yang)

The head nurse liked abusing others. She had a very bad temper. Some words really hurt your self-esteem. She abused you in public, which made you feel bad. Then you lose confidence because you were worried whether they heard that the head nurse had abused you. (Bo)

Many participants felt hurt by the rude and the dehumanising attitudes of nursing managers, which reduced their respect for nursing managers. Meanwhile, the interpersonal conflicts between nursing managers and clinical nurses also influenced proper staff evaluation and financial reward. This unfair treatment could not be ignored as contributing to some nurses' leaving, as several participants commented.

One of the nurses was one year junior to me. She was supervised by me for a short time and she was excellent. When she did something, she did it perfectly. However, the head nurse did not like her because they did not get on. She was suffering and there was no way to change the situation, so she always asked me to help her leave. She could not stand it anymore (Bo)

How much bonus you got was a secret of course, you could not tell others how much you got when the head nurse distributed the bonus. It depended on who were preferred by the head nurse. Meanwhile, we needed to do self-assessments and peer-evaluations monthly, but I would say if you did not value yourself highly, nobody would speak for you, so it was just a performance to make us busy. (Xue)

The bonus system and the secret financial rewards were commonly used by the nursing managers and hospital administrators to control the nurses' obedience and

punish the nurses' disobedience, which created a collective pressure to keep silent for the nurses whose personal and professional values were in conflict to the dominant group. However, although some participants indicated that bad interpersonal relationships did negatively influence some nurses' decision to stay, the majority of participants thought that they usually had kept a good relationship with the head nurses, like Yun said.

No matter where I stayed, I could deal with the relationship with the head nurse and colleagues perfectly. I was proud to say that I was well regarded as a good staff by them. (Yun)

Although some conflicts happened, they have adopted different strategies to keep a harmony. Bo gave a detail example.

The attitude of the head nurse towards me made me feel very bad and very sad. The following several days, I did not want to work anymore and felt more and more bored day after day. My cousin thought it was because I did not give her a gift. He gave me a LV handbag and told me that I must force myself to give the gift to her, so I did it. Since I gave her the bag, our head nurse might think...maybe it was not because of the bag, she thought ...I might want to communicate with her and was nice to her. She had a very bad temper; afterwards she was really nice and kind to me. I had more chances to go out for further learning than other younger nurses. I have mentioned that our head nurse had controlled parts of the secret financial reward in the unit and she often took us to some nice places to have dinner. Just some of us, and one table, we also could take our family members, which I thought very nice. (Bo)

Although only one participant implicitly revealed the dramatic change after she initiated communication with managers through the giving of a gift, many participants would agree that keeping a harmony with managers and colleagues was important in order to avoid being isolated in workplace.

Some nurses had good relationships with the head nurse, and they could be exempted from night shifts. Sometimes, the head nurse secretly gave you the theoretical tests in advance, so that you could have good marks. (...)The relationship was not formed by your good work. That is why I thought there was no future working in nursing. (Gao)

The head nurse and group of charge nurses who were close to her liked to exchange material gifts. I did not like it but they would isolate me out of their group. They would not offer any help when I needed immediate assistance to cope with the overload of tasks in the workplace. (Rao)

The appearance of harmony covered the different levels of implicit personal and professional conflict between nurses and nursing managers, who did not openly discuss fairness, which has had a negative impact on effective team work during clinical care towards good cooperation for the quality of health care.

Comparing the participants who left nursing practice because of the negative interactions with their nursing managers, many participants did not have negative comments about their nursing managers.

The director of nursing wanted to promote me. I did not want to be promoted. My head nurse could understand my leaving. What does the head nurse mean? I can tell you that they contribute the best years of their life from age 35 to 45 for the hospital, regarding the hospital as home and dedicate their life in the wards. Then they would lose their positions at the age of 45. They need to make space for young people. I never reached this lofty ideological status. (Ling)

My head nurse was an honest and kind person. She had never married until now and was aged 45. I thought that she really dedicated herself to nursing. She really trusted me and let me take the responsibilities. No matter how hard the work was, we shared the responsibilities and happiness working together in the unit. I would continue the hard work as usual since I valued the friendship. ... But once she could not control her tears when she was required to self-criticise in front of all staff of the hospital. I did doubt whether such dedication for the hospital was worth me following. With her full understanding and support, I decided to leave nursing. (Yun)

One head nurse was really outstanding in nursing with a nice personality and she had published many articles in top nursing journals. I admired her. However, when she was near 50, she was asked to work in the Logistic department. She refused: "I would like to be a nurse rather than do a non-nursing job." Now she needs to do the same tasks as a young nurse. She told me that it was meaningless after working in the hospital for so many years. What a pity! Very wasteful! She had very good professional competence. (Bo)

This group of participants truly valued and admired their nursing managers' hard work and professional contribution through closely working with them. In recent years explicit or implicit age discrimination for nursing promotion became popular and was manipulated by the president of the hospital. Low morale was pervasive among current hard working nursing managers, since they perceived that what they

valued as long term service and contribution to the hospital had not been properly rewarded. The nursing managers with low morale usually gave their personal support or acted as a model to encourage their favourite staff to leave nursing practice rather than stay for a promotion.

Currently, open competition for promotion has been introduced into nursing workforce management. However, many participants have pointed out that the limited chances for nursing promotion were not truly openly acknowledged under the bureaucratic management system.

The limited chances might depend on how well you work, but the most important is how much social resources and network you established. It is very tiring. I think the leaders' favourite will be selected. (Qun)

When I looked around in the hospital, honestly, I really think that there are too many factors other than nursing profession criteria that could affect the promotion. (Yang)

Under the bureaucratic management system, the chance and criteria of promotion were based on the different level of leaders' personal preferences rather than professional evaluation. It could not be denied that limited promotion might result in an unequal and unethical competitive environment, as Gao revealed.

If the leaders said that you were not a good nurse, your efforts would not be recognized no matter how hard you try. Some nurses are good at establishing personal relationships, but are ugly. I mean if you were a beautiful woman and a leader fancies you. (Recording stopped to delete the detail as she requested) ...Through dancing, drinking and playing cards together or even through sexual relationships, later they would be promoted to a very good position. Some of them became very arrogant after they were promoted in this way. They would preach to us how we should perform and organize very strict tests. I despise them from the bottom of my heart. I hope that a woman, no matter how beautiful and capable she is, should at least do something depending on her own knowledge, or live on her knowledge. (Gao)

The issue of sexual harassment raised by one participant could not be interpreted as a common issue in the hospital, but it does suggest that that sexual harassment did happen and may cause some nurses to leave nursing either by refusing to be a victim or by refusing to work in such a work environment.

Among the all participants who left the hospital, only Xia expressed satisfaction about her promotion. When I asked whether she thought her promotion was decided by her work performance, she frankly told me:

There were multiple reasons, firstly, the director of nursing was from my hometown and she had a good impression of my work performance through feedback from the head nurses. Also the president of the hospital was my husband's supervisor. He already suggested that the director of nursing gave me a good arrangement. The director of nursing told me that I could apply for the position. (Xia)

Many ambitious participants felt unhappy to be supervised by less qualified nursing managers in the workplace. Gao articulated a similar feeling to many.

I was very clear that one of the head nurses could not do nursing well by herself as I worked closely with her. She was the kind of person who did not follow the formal procedures in practice. When there was nobody nearby, she would throw the whole infusion tube, without separating the needle, into the bin with disinfectant, which might cause other workers needle injury and infection when they deal with the medical trash since they did not know how to protect themselves very well without proper training. She recorded the blood pressure on the report without measuring it on the patients. She had a very bad work relationship with colleagues. However, the director of nursing liked her very much and she was promoted to be our head nurse. When she became the manager, she would strictly blame us in turn, which is very disgusting. I felt very sad when she came to examine me. (Gao)

To challenge their managers' incompetence, the participants expected that nursing managers could be promoted through their professional efforts in nursing. However, it needs to be cautioned that the majority of nurses working in the Grade three hospitals are highly qualified and well educated, which means that the limited managerial positions for promotion in a nursing career could not meet all the requirements of nurses. It may be interpreted by some ambitious participants that the hospital managers under value their professional capability to be promoted. It is understandable that the participants generally lose enthusiasm to join in the highly competitive but unpromising promotion ladder.

4. Struggling to meet career progress

Apart from the limited chances for promotion, the patterns of nursing and medicine career paths in the Chinese health care system are similar (Appendix 8). The guideline of the examinations and the requirement for publications for nursing career progress was set up by the national and provincial health authority. Meanwhile the hospital level of examinations and spot tests was organized by the nursing office in each hospital to emphasise standards of care and nursing professional status. Therefore, Chinese nurses are required to pass different hospital, provincial, and national regular examinations, spot tests and fulfil publication requirements in order to make career progress within the hospital.

Qun typified the positions of many when she talked about the conflicting feelings regarding the regular examinations.

*Qun: You might think we just work hard every day, but we also had taken many regular theoretical and skill tests... I **don't mean** that I left my job because of the theoretical test (Smile).*

*Zhu: It **did not** relate to your leaving?*

*Qun: Well, **it is** one of reasons. I understood that the strict examination should be good... It should be helpful to the improvement of nursing standards, but maybe I should say that I really didn't have the energy for that. The tests are necessary, especially for the young nurses. As a senior nurse, really, sometimes when I went home, there was no time to read books for the test.*

Although Qun expressed her understanding that the examinations were necessary to improve quality of care, spending a large amount of off duty time to prepare for them has increased her stress in balancing family life and work commitment. The frequency of regular examinations is similar in different hospitals.

The regular nursing skill test might be necessary to maintain a standard in nursing procedures, but frankly, I could do all the things in standard ways in the tests, I didn't follow all the rules in working, otherwise I could not finish the tasks. ... Because nurses frequently had to take regular theoretical and nursing skill tests, and we had to use our free time to prepare and take the tests, so we became irritated and felt very stressful. (Ling)

From their explanations, the majority of hospital level examinations repeatedly checked the standard fundamental nursing knowledge and skills. However, Ling typified many of participants views that passing the tests could not ensure nurses carried out standard practice under heavy workload with the time and staff constraints. The gap between theory and practice has been previously discussed in Chapter 4. Whether they were good at taking the examination or not, nearly all participants commented that these examinations did not improve quality of care for the daily clinical practice, and became extra burden for nurses. Some extra examinations are slightly different among the units and hospitals. However, the common challenge is that there is a lack of opportunity to discuss whether the examination is reasonable or not within the hospital. Bo introduced her experiences as both examiner and examinee.

The nursing office made plans to evaluate the nurses by theoretical and skill tests each year. The point is that the leaders do not know how to evaluate a nurse, so they have to use tests. When I was working in the nursing office, I have designed and assessed the tests. Actually, I thought that I did not put myself in the nurses' shoes when I prepared the questions. I just finished my task by picking questions from the textbooks. I had no time to judge seriously if the questions were of any significance to the nurses because of my heavy workload and the limited time available for the task. Some questions were out of date. I felt that they were meaningless... (Shaking head) I would say that I was scared about hospital tests, because sometimes your mark might not be good even if you read lots of books. The person who designed the test is not necessarily from your clinical area, so she may put in a lot of questions which are not relevant to your practice. Some questions are too detailed with a medical orientation, which you might never encounter in your daily work, but all nurses in different units must take the same test at the same time, so you would surely make some mistakes. ...You may have learned some content, but you could not remember everything because you did not use them at all in daily practice. Nurses have to study and are always anxious. It is very exhausting. It is possible that a nurse with very good performance in daily practice gets a very low mark in tests. It really hits your self-confidence. (Bo 192)

From the participants' view, these strict and regular examinations did not help them in personal and professional development. The current examinations seem to become a symbol of nursing standards without supporting evidence. Since the content of the examination is not very relevant to daily nursing practice, it will be easily forgotten after the test. Nevertheless, from the perspective of nursing

managers, nurses should have a strong theoretical knowledge base and gain respect for the nursing professional reputation.

Everyone feels sorry if they get low marks... The head nurses want everyone to compete for a high mark and hope that their units can be one of the top three units within the hospital. No one likes to be the bottom . (Yang)

I admired the director of nursing and head nurse who had solid theoretical knowledge. The director of nursing could even deal with medication in ICU better than the doctors. She said that if our nurses could know medicine as well as nursing, then the doctors would never look down upon us. I am afraid that I could not reach their level. (Qun)

The different levels of nursing management are very strict in examinations, which created invisible pressure for nurses. I just wonder why doctors did not have to take so many examinations, although they continue to develop in their career (Chen)

Often we had to go for further study in the evening. Then the doctors would say: "Why do you study? You are always the same no matter how hard you study." While you took the Three Basic Examination, the doctors looked over the questions in the book: "Why do you learn these questions? It is impossible in reality. " (Ting)

Participants felt disappointed by taking the meaningless but stressful repeated examinations. After nurses had experienced undesirable oral or formal examinations day by day, they generally became scared of the examination, and eventually nurses admitted that they had less theoretical knowledge than their leaders and the medical staff. However, whether nurses complain, hate or panic about the frequent examinations, they had to study hard to pass the examination for normal career progress.

In order to avoid being stepped on, you must... rush forward. (Ting)

Everyone upgrades their professional post, so I need to keep my face. Otherwise, people would even say that you did not have the capability to make progress in your career. It is little related to the financial rewards. To be honest, I just follow the crowd and don't want to lose face. (Xue)

Many participants expressed that they prepared for the tests just because they did not want to be the last in the managerial evaluation. The data indicates that the nurses' collective expectation is to go through a normal career path by meeting the

requirements of hospitals, but it seems not to involve nurses' actively learning for clinical improvement.

Meanwhile, nurses had to accept different internal and external spot checks during their daily practice. Qun gave a detail explanation.

Apart from the monthly examination in the unit, the nursing office would check clinical nurses' work performance each season. (...)The problem is that although the nursing office came to check just once in three months, we did not know when they would come, so we worried about it all the time. Meanwhile some delicate unusual questions in the tests are really too difficult to memorise, so I became really scared of it. My most relaxed time was when the check had just passed and there were no other tests waiting to be done at that moment. This was the happiest time for me without being afraid of examination. (Qun)

If you were good at theoretical knowledge, you were asked to prepare for passing the internal and external evaluations for the unit, since they may test you by asking questions. According to your capability, you will be arranged in different positions to wait for inspection. Everything is false.(Xue)

The Health authority also gave surprise tests for nurses. Once, two nurses were randomly selected for a nursing skill test in a hospital. One was on her wedding day, and another nurse was pregnant, but the president insisted that they should take the test. If I were in this situation, I would resign immediately. (Xia)

From a nursing managerial perspective, all these efforts might be seen as a means to improve the standard of care. There are similarities with how the airlines maintain quality in safety by spot tests before a flight, which are described in the classic study of emotional management by Hochschild (1983). While nurses have accepted regular official checks and examinations, it has resulted in a great discrepancy between their daily practice and their ideals and values of professional nursing, which further negatively impacts on participants' professional identity.

As well as passing examinations, writing essays or publishing articles became a normal academic requirement for nurses who wished to rise to medium and senior professional posts.

Now the requirement for a senior professional post in nursing is that the nurse should publish essays in the top nursing journal. One of my colleagues copied an essay from another journal; she only changed the names of the authors and some data, and then published it. She put my name as her co-author. The essay is meaningless. Do you think such a requirement is worthwhile for us? (Xue)

However well you have done in clinical care, you could not achieve a senior professional post without publications. The evaluation system is problematic. I think that our country wasted nurses' time and money by forcing the clinical nurses to publish articles in a miserable way. (Chun)

The demand of writing essays makes me suffer. The problem is that we have only received education in a technical secondary school and don't know how to write essays. How do we write essays? We read essays of other authors and try to imitate them. Meanwhile it depends on which journals are acceptable to the hospital. Some journals are very profitable now. You pay and then can publish your essays. It was a burden because of this demand. (Ling)

There is a lack of positive feedback about the essay requirement from the participants. Participants felt a dilemma when they were required to have publications but without efficient research training to do so. Many nurses accepted plagiarism as normal for publishing under the current essay requirement. Apart from several junior nurses, who have not been concerned by the essay requirement for their professional posts, the majority of participants regarded the essay and publication requirement as a meaningless, tough task without academic value. Yuan's comments represented the doctors' perspective of nursing publication.

I think the essays in nursing are all very simple. The aim is to publish the essay in a journal. Actually it is the same for the doctors. There are not many real meaningful projects. It is not easy for the nurses to write essays, because they have not received training in this respect. I think that most of the essays are a result of oppression. The nurses can edit their own journals, which can be more suitable for them. (Yuan)

Yang felt it was difficult to get support for the essay requirement within nursing.

I hoped that I could get support since I had very limited ability to write an essay, but it is very difficult to find someone who can guide you in the nursing group, because everyone is in the same situation and tries to find a way forward. No one is confident to make some improvement. (Yang)

Without efficient research knowledge and a clear awareness of the academic requirements, the essay requirement for nursing professional posts has become a burden for clinical nurses. Although Bo did not worry about her personal essay requirement since she was quite good at writing, she was upset that she could not meet an increasingly high expectation from the head nurse and the medical directors about the essay and research projects requirement.

I did whatever the head nurse told me to do. I wrote many articles for her, including literature reviews, case studies and the unit annual report. Some of the articles were used for publication in journals. She gave me a subject and let me write it up. She made some changes after I had finished writing. I actually felt very sad to be in such a situation for a long time. I did not feel sad because my name was not put on the front. The key problem was she did not give me a break. After I finished one essay, she would say: "you are free now, let me give you another task." It seemed that she was training me, but I felt that she was taking advantage of me. After pressing me to do some things, she would say: "We have a chance to let a nurse travel somewhere, and I will let you go." ...The head nurse did not have a good relationship with the medical director, who would talk like this: "in the ICU, your nursing team must do a research project this year." In order to save her reputation, the head nurse transferred the pressure to me. I felt that I did not have the confidence to do the project although I had the desire to do it well, because I had to depend on myself without mentors. I felt especially tired. In addition, I had to deal with the daily work. But nobody could understand what I had done, so I felt that I was doing something meaningless and aimless. I decided to leave nursing. I told the head nurse that sometimes I felt inferior and not confident because there was a big difference between the nurses and the doctors. The head nurse said I should tell the medical director that doctors push the good nurses to leave. Actually the most important reason was that nobody helped and taught me how to do the research projects. I thought that it is a long way for me to do the research projects by myself. (Bo)

Under increasing academic demands without proper research training, Bo eventually lost her confidence in writing essays and doing the research projects without understanding and support in the hospital. It appears that research projects and the capability to do them became a key issue for her leaving. The medical criteria in doing the research project caused her to feel inferior to doctors. Meanwhile, plagiarizing from junior staff's hard work and essays was implicitly accepted as normal by the nursing managers to meet their publication requirement for promotion and career progress. Bo felt that she lost any value and meaning of her hard work, which was echoed by many participants.

Some ambitious participants actively take more challenging examinations in another career rather than accept the unreasonable examinations within nursing.

Some people chose to go for further postgraduate learning. Some of them took English test and planned to work abroad. (Yuan)

I really do not like to take the examination. At that time, I just want to find some books to read more interesting than nursing. Then I took up the law books and I found I really enjoyed studying law. After three years, I passed all the exams and registered as a lawyer. (Gao)

Many participants actively quit the intense competition for career progress by leaving nursing since they thought that the hospital wastes nurses' valuable time and energy.

I could not find a meaningful goal in my nursing career. It was a waste of time, money and energy. Why do I go through so much pain to insist on making an effort? (Chun)

It is not a place to show your value, but the competition is very intensive. However, it is stupid to compete in this place. What can you get after the competitions? You won't get a lot of benefit in the end. In addition, the small benefit is not worth you spending a lot of time and energy to fight for. I once said in a cynical mood: "Damn it, all the nurses staying in the Hospital are losers and the leavers are winners." (Ting)

Although career progress in nursing seems equal to medical professional development and has been used to emphasise nursing's professional status by the nursing managers, the strict examinations, research and publication requirement follow medical criteria that seem to undervalue nursing expertise and discourage nursing autonomous development. There is a potential danger for nursing to be de-professionalised by pursuing nursing career development. The unprofessional evaluation about nursing work performance does not properly reward the great efforts made by nurses. The majority of participants left nursing since they thought that they did not have the prospect of a future as a clinical nurse.

5. Summary of 5th data chapter

The data indicates that there is a lack of management support to retain the nursing workforce in the ideal workplace. Nurses' voluntary leaving is regarded as the loss to individual nurses rather than the loss to organizations and society. By emphasising nurses as replaceable labour, the nursing managers and hospital administrators did not value nurses' hard work and professional contribution. Based on the power imbalance in the employment market between the nurses and the Grade Three hospital, the individual nurse rarely possesses bargaining power equal to their employment status and promotion. Meanwhile powerless status nursing managers avoid problems they cannot resolve or even ignore the nurses' explicit requirement for an active solution, since it is beyond their own interests. The managerial view that nurses had to stay because they were lacking of capability or power to leave nursing practice, inevitably impacted on the morale of the current nursing workforce. The evidence has illustrated that nurses had to balance the conflict between their interpersonal and professional relationships without a united front in the nursing workforce. The current nursing career progression, following similar criteria to the medical career path, has potentially undermined nursing professional development. Nurses who value nursing as a professional occupation rather than a job for life eventually lose enthusiasm in promotion and career development in the organization.

Chapter 8 Meaning of leaving

1. Introduction

The analysis in the last data chapter focuses on why nurses do not have reasonable mobility in their nursing career, and how participants struggle to balance their work and family commitment. Two themes emerged from the participants' account of the organizational controls, which influenced nurses' willingness to stay.

- Lack of reasonable nursing mobility
- Limited maternity and sick leave

In the last data chapter, it is perhaps worth reminding ourselves that there is a widely held view among Chinese hospital managers that nurses' leaving is an individual problem but not an organizational problem. On these participants' accounts, they were acutely aware that leaving the organization often means leaving a nursing career permanently.

2. Lack of reasonable nursing mobility

2.1 Within the hospital

It is impossible for Chinese nurses to directly apply for a specified nursing position according to their personal and professional interests, since there is a lack of transparent and clear recruitment information on nursing vacancies in the Chinese health care system at local level or nationwide (Chen and Liu 2010). New recruits are generally allocated into different units by the director of nursing without discussion.

As the previous data reported (see chapter 4), Li and five other colleagues tried to ask the nursing office to allow them to work in the in-patient department rather than in the relatively relaxed out-patients department for the “good image” of the hospital,

but their requests were refused by the director of nursing. However, in her motherhood with a 5-month old baby, Li was required to work in the most stressful Respiratory Unit and when she asked to change units for her baby's health; she was relocated to a remote clinic centre which took her two hours of travel on the shuttle bus.

As a junior nurse, I was required to start each shift half an hour earlier than the senior staff, but the earliest shuttle bus only arrived at the remote clinic on time for the normal shift hours. I would reach 3 years work experience in one month, the director thought it was reasonable for me to take the shuttle bus, but the head nurse insisted that I must follow the same rule as a junior nurse by cutting half of my breastfeeding time each day. (...)I decided to resign. The head nurse said that it was a pity for me to leave since I could independently do a good job and would get the standard payment now after I had worked for three years. The director of nursing said that she could transfer me back to other units in the city centre, but since I had already been in all units in these three years.... I decided to go back home, at least I could take good care of my baby. (Li)

Li has complained that she got unfair payment as a contract nurse. She would get relatively equal pay to the permanent staff when she reached 3 year experience in one month's time, but she still decided to leave for her baby. I wondered why she seemed uninterested in the managers' suggestion for her to stay.

Zhu: If in the first year, you had worked in the Respiratory Unit and in the third year you worked in the out-patient department, do you think you would have left nursing?

Li: It would be totally different and I would not have left nursing. My colleagues also talked about the work allocation made by the nursing office. They said if they were me, they would leave earlier since they knew my family financial condition was quite good... but I liked being a nurse. (...)Some young colleagues also wanted to quit, but I suggested for them to be cautious unless they had their family support, since it was very difficult to find a nursing job after leaving.

From the above conversation, a potential increase in salary was not sufficient to convince Li to stay for life in the organization based on her good family financial background. Since the nursing managers did not provide reasonable mobility in the past three years, Li decided to leave for her baby, although she perceived the difficulty of returning to her nursing career later. The nursing office allocated nurses mainly based on their managerial priority without professional orientation and a lack

of caring attitudes to individual nurses, which may significantly cut the working life of their young nursing workforce.

Seeking an alternative work environment became a necessary requirement for Chinese nurses since their personal or professional needs could not be met within their work place. However, the nursing managers generally perceive nurses' mobility between units as troublesome, which was further confirmed by the participants who had worked in the nursing office.

A few nurse cried in the nursing office since they did not want to stay in their current units, but few nurses could get permission to move in the hospital. The director of nursing thought that it was a tough task to transfer nurses between units since there were too many nurses with similar requests, and she was too tired to deal with such requests every day. Therefore, she decided to refuse all the requests. My heart sank when I heard that I had to go back to the ICU from the nursing office, but I knew that I had to go back. (Bo)

When I worked in the nursing office, I was worried that I might be sent back to the previous unit later. Then I thought I should find a way to avoid being transferred back to the unit by leaving nursing. (Rao)

These participants chose to leave nursing while they clearly realized the difficulties for nurses in finding suitable units without the nursing managers' support. It was common that Chinese nurses in Grade three hospitals were frequently transferred from one unit to another unit without discussion or mutual agreement in order to meet an emergency clinical workload under a critical level of understaffing.

I was originally asked to be a helper going from the TB unit to the unit of Obstetrics and Gynaecology, since there was a shortage of staff. Then I was told I must stay there. Someone said that the head nurse in the previous unit did not like me and someone else said the head nurse in the later unit liked me and wanted me to stay. I did not know what was true, but I was working in the TB unit for more than 3 years and suddenly I was thrown into the unit to be a midwife. I did not even know how to help with delivering a baby. (Ting)

I was trained as a midwife, but I was located in the neonatal unit and only changed the diapers and fed milk to the healthy new born babies for more than three years. I was worried that I would forget what I had learned and could not pass the examinations for career progress if I continued to stay in one unit. Then I managed to ask for help from one of my senior colleagues who was very clever in communication with leaders but not good at hard

work. I helped her work and she helped me to persuade the head nurse that I could move to a Gynaecology Unit. My colleagues said that I became wise now since I was the first one to move out. (Yun)

The role of nurse and midwife was ambiguous in Chinese hospital human resource management. Ting felt concerned that she must work as a midwife although she only had nursing training, while Yun was frustrated that she mainly practised as a nurse with midwifery training. The misallocation of nurses in the hospital has inevitably reduced the effectiveness and efficiency of the available nursing workforce. Ting and Yun's opposite experiences indicated that the nursing managers may not treat nursing as a profession based on training and work experiences, which undermines nurses' professional identity. Meanwhile, a lack of transparency and professional discussion about nursing mobility brings explicit or implicit moral judgement about the nurses who are re-allocated, which causes unnecessary frustration due to personal and professional conflicts. This is further confirmed by Yan's leaving.

One of my colleagues told me, that the head nurse sent me to another unit since she thought I was not getting along with them. (...)I started to enjoy nursing in my second unit, but one day I was told that I must go back to fill in the shortage of staff in the previous unit. I really did not want to go back. I asked the head nurse whether the arrangement would be temporary or permanent. She said she did not know. There is no negotiation after a decision made by the nursing office. Then I asked for two weeks sick leave and hoped another nurse would fill in the emergency staff requirement. However, after two weeks, I was still required to go back to the previous unit, and then I said that I would resign rather than be transferred. ... I would not have left nursing if they had not make me go back or even if the first unit did not kick me out first. (Yan)

Yan asked for sick leave as a strategy to avoid the unpleasant arrangement. She did not want to give up the job since she started to enjoy nursing practice at that time. However, the nursing managers deliberately ignored her personal feelings and resisted supporting her to stay. Yan complained that she had to resign but she still had to pay the hospital 15,000 Yuan as a fine for her leaving.

Zhu: Did you read the contract carefully before you signed it?

Yan: I had a glance at the terms of the fine. I knew it was unreasonable but I had no choice. You must sign it in that situation.

Zhu: What are the details of the contract?

Yan: If you ask to leave the hospital within five years, you must pay 15,000 Yuan, or 5000 Yuan after you have worked here over 5 years, since you breach the contract. I had thought of the problem of the fine when I planned to quit my job. The hospital is too powerful. The terms about the fine are completely added for the benefit of the hospital.

Zhu: Oh?

Yan: Actually I did not want to pay the 15,000 penalty for my leaving. It is against the new Employment Law, but my parents and parents-in-law all said that I should not offend the hospital, as the hospital is an influential institution which might negatively influence my future, because I might need their reference for a job one day. From their perspective, it was already outrageous behaviour that I resigned from the hospital.

As a nurse with good family financial support and social resource, Yan refused to accept the managerial control of the unit allocation by leaving. However, it sounds surprising that Yan could not resist paying a great amount of money for her leaving, which was nearly equal to her total salary for a whole year's hard work. The case of Yan might be explained that she was recommended to work in the Hospital by her father-in-law through the social network, so they did not want to offend the authority of the hospital in order to maintain the social network. Nevertheless, the evidence demonstrated that the powerful organizational control over nurses in the Grade three hospital was well-recognized by the individual nurses and the society.

Xia has worked in another hospital for 9 years, and her contract was renewed every two years, but she also had to pay 5000 Yuan for leaving the hospital. When I asked her whether she thought it was fair for her. I was surprised that she said that she was happy to pay for leaving.

Why? Because if there was no such condition for leaving, for example, some hospital did not renew the contracts again, they will not allow you to leave. That would be troublesome. So, I can understand, if I want to leave I would give money for freedom. (Xue)

The participants fiercely competed to work in the ideal workplace (Chapter 4). Based on the power imbalance in the employment market between the nurses and the Grade three hospital, the individual nurse rarely possesses equal bargaining power to their employers when making a contract. From the participants' accounts, whether they

had general agreement or even got into trouble for their leaving, it is clear that there is a lack of general awareness and policy to retain the nursing workforce with support from the nursing managers and hospital administration. The compulsory unfair contract reconfirms the legal position of the hospital and forces the nurses to pay a high price for leaving the hospital without disputes. It not only further undervalues nurses' hard work and contribution, but also re-emphasises that nurses' leaving is an individual problem not an organizational problem.

It needs to be noted that there are several participants who were successful in moving within the hospitals with support from the hospital leaders.

We made great efforts to find a way to directly contact the president of the hospital through my husband's social network. It was very difficult, but later I was transferred to the X-ray department with the president's support. It was a very good position for a clinical nurse, where I was only responsible for the patients' register and a few X-ray catheters.

The president of the hospital was my husband's direct boss¹⁵, so he told the director of nursing that if there was any good opportunity available it could be offered to me first. I accepted the position as a clinical teacher since it exempted me from night shift. (Xia)

A good position working in the hospital for Chinese clinical nurses usually means less stress workplaces which exempt night shifts. The main reason for being successful in moving was that they had support from the hospital leaders, who have more authority than their direct nursing managers. Although the participants who had more social resources could gain personal control for their mobility in the hospital, they more clearly realized that the hospital leaders actually did not respect nursing as a profession and did not value the nursing contribution. This awareness tended to underestimate the authority of nursing managers and the value of a nursing career, since staying in a nursing career could not help them to increase self-esteem and gain respect as a professional nurse. It is understandable that they lost enthusiasm to stay in nursing although they could get a good nursing position.

¹⁵ In China, many postgraduates call their supervisors as "boss".

In the generally over stressed nursing work environment, a good position in nursing clinical practice was rare. Doing a non-nursing job but still working in the hospital became a more attractive choice for Chinese nurses. This has become the first choice for Chinese nurses during their period of decision making about leaving. Sun currently worked at the Staff Health Centre as an administrator.

Sun: Very annoyed, after I transferred my job, I dared not eat at the canteen. ... (0.3) very annoyed.

Zhu: Why?

Sun: 'Look, look...the one who married a good husband has come here now!' (She punched my shoulder to show me the way people would say hello to her. The heavy pat expressed the jealousy of her colleagues and her complex feelings.) I said to them that I was sick, so I had no choice.

Zhu: Why did they speak like that?

Sun: I was lucky, just lucky. If you were really sick and the leader did not care, I might leave the hospital. It was not my husband's capability. Anyway, if they would like to keep saying...up to them. ...To be honest, although I was still within dingbian, the office job workload was much less, which was impossible in clinical care. My husband earns much more than me, so I was quite relaxed to take care of my health and my son. ...Today I will leave the office earlier since I need to pick up my son and bring him back to the hospital to see the dentist.

Zhu: So it is convenient to work here. (Smile)

Sun: (Nod, she shows a very satisfied smile) ... it was lucky to work here.

Sun expressed gratitude for the leaders' help, although she did not plan to tell how she got the current position. However, from her colleagues' attitudes to what she called "lucky", it seems that a non-nursing work position within the hospital has resulted in collective jealousy or admiration from the nursing colleagues who had to stay in clinical care. As Xue pointed out, the privileged offers from the leaders were impossible to attain for many of the others without powerful social resources.

My husband said that we could look for a chance to transfer to a less stressful department in the hospital rather than leave the hospital, such as the Physical Examination Centre. We tried hard, but it was very difficult to get it. The head nurse did not allow me to transfer. (Xue)

In order to further understand the phenomena of changes in non-nursing positions, I followed four other former nurses who are currently working in different non-nursing

positions in different hospitals. Chen frankly told me that the leaders who are working together closely with her husband in the Health authority helped her to leave nursing practice.

The government document addressed that some non-nursing positions could be a reward for the nurses who have worked in the Medical Team in Africa. Also the leader of the Health Bureau has helped me to communicate with the president of the hospital, so I moved to the Personnel department. The head of the personnel office is also a nurse. We still are belonging to nurses within dingbian. (Chen)

Like Chen, the other three participants, who left nursing practice but retained their *dingbian* as nursing personnel in hospital, also had special social networks with the Health authority, which helped them to get the support from the president of the hospital by a personal or organizational exchange of power and resources. The more powerful social resources the nurses have, the more easily they would transfer to the relatively less stressful non-nursing work environment in the hospital. This group of nurses is estimated to be about 9 to 15% of the whole Chinese nursing workforce within *dingbian*. The wastage caused by the hospital administrators not only increased current clinical nurses' workload under the vague official statistics about the number of nurses, but also negatively impacted on the morale of clinical nurses.

2.2 Between the hospitals

Some participants hope nursing is a career for life, but not a job in one hospital. However, there are many barriers for Chinese nurses wishing to move between the different hospitals.

If I could change my practice environment to another hospital, maybe I wouldn't leave nursing. I love nursing, although it is a hard job. I thought that nursing should be a career for life but not a job in one hospital. One of my colleagues wants to move to another Grade three hospital, but our hospital did not allow her to move. (Yang)

The hospital was not exactly the workplace where I would have liked to stay. I would like to have worked in another hospital and find a suitable environment in which I can work better. I wish that nursing could be a career for life. (Bo)

As Chapter 4 indicates, the *dingbian* system became the main restriction stopping the permanent nurses from changing employment between hospitals. If they wanted to change hospital without the agreement of personnel management from the hospital with which they were employed they would lose a stable job with social welfare, health insurance and financial benefits within *dingbian*.

Two participants were transferred into the Grade three hospitals from the low grade hospitals when the latter institutions were merged into the former one.

When the previous hospital was merged into the Hospital, a great number of nurses from my previous hospital left nursing within six months. They could not get used to the high pressure. It was really the hardest time for me. I needed to get used to the new environment, so I used to read more up-to-date books every night although I needed to take care of my 3 year old daughter. Actually, working in the Hospital is the biggest reward ... I encouraged one of my friends to keep going to get through the transition. However, in the beginning, with 9 years of work experience, I got even fewer bonuses than the new recruits I supervised. It was impossible for us to get promoted in the Hospital, since we were from the low grade hospital. (Qun)

We joined in the Hospital, which is bigger and more famous than our previous one. The work was really hard. I only remembered that all of us must go to work earlier at 7am, but could not get off the day shift until 8 pm....I was young at that time. One of my senior colleagues was in tears. Meanwhile, we needed to take lots of tests, which we did not have to do in the previous hospital. The pressure seemed too great for us. (Ting)

In recent years, following an unequal health care resource allocation between different grade hospitals, the low grade hospitals and community health centres tended to be marginalised while the Grade three hospitals tended to merge with low grade hospitals and to expand their service which was encouraged by the government with a profit driven orientation. However, the unusual hospital restructuring resulted in many nurses who previously worked in the low grade hospitals being laid off, since they could not endure the organizational transition. The nurses who worked in low grade hospitals were usually regarded as less qualified staff, when the low grade hospital was merged into higher grade hospitals. Although the two participants experienced a more stressful work environment and successfully managed the transition process, the discriminatory attitudes from the

leaders and their nursing managers continued to undermine the individual nurses' efforts with unprofessional nursing evaluation.

It was unusual for nursing mobility to happen between the different grades of hospitals in China. Meanwhile nearly all participants confirmed that it was rare for nurses to go back to Grade three hospitals after they left.

So far, I haven't heard of anyone who went back to the previous hospital after leaving, which is impossible without a special social network. (Gao)

In general, it is understandable that you would not like to go back. You would face higher pressure, because the first time you were equal to your colleagues, but if you return to the same hospital after leaving, they would look down upon you and be more demanding of you. They would say you would never return if you were a capable person. (Yun)

When participants were asked whether there was any possibility for them to contribute their nursing knowledge and experiences in the future, no participant expressed any possibility for them to work in any Grade three hospital as a nurse again. Li was the only participant still looking for a chance to be a nurse.

I would like to work as a nurse again after one year. There is no recruitment information available on the hospital website. It is difficult to find a position to continue nursing practice. I did not go to any Grade three hospital since the Grade three hospitals only accept new graduates with a bachelor's degree with contracts. (Li)

The data clearly demonstrated that the current Chinese Grade three hospitals did not welcome former nurses back, since the administrators of the Grade three hospitals prefer to recruit new graduates rather than to retain experienced nurses. All the hospitals recently tend to recruit contract nurses without *dingbian* rather than to employ permanent staff within *dingbian*, which has been regarded by the hospital administrators as an effective way to control the staffing budget. Meanwhile, under the current recruitment strategies, a former nurse who considers returning as a nurse in the same hospital might be regarded as an incapable person by current leaders as well as by nursing colleagues. The negative culture towards resignation and possible return further stops the leavers actively planning to go back even if the conditions

could be available. Like many participants, Xia was aware of resignation as a permanent decision to leave a nursing career.

My nursing knowledge might only be of benefit to my family. I do not think that I will return to be a nurse. If I stop practice in nursing for a while it would be difficult to pick up again later. (Xia)

Some participants expressed that under certain conditions, they might have the chance to use their nursing knowledge and experience again. However, they found it difficult to continue their nursing practice without a legal registered process after they left the hospital. Qun expressed that she was willing to practice as a volunteer nurse, but she realized that it was impossible for her to keep practising in the hospital.

The head nurse has told me that she would call me for help if it was too busy. I said I would be glad to be a helper if she called me. Several days ago, I visited them and they were so busy at that moment. Therefore I put the uniform on to help them. I signed my name, but then I realized that I could not sign my name now. One of my classmates warned me that the next time if they asked my help to do the PICC, I should not go again, because I was not a nurse within the hospital, nobody could protect me if anything went wrong. I could voluntarily be a helper, but there was no protection for my practice now. (Qun)

Although Qun was voluntarily willing to contribute her expertise for her colleagues and patients as an experienced nurse, the reality was that without organizational permission, a qualified nurse practicing with patients within hospitals is illegal in China.

Several participants thought that it would be better to go back to their hometown rather than stay in the city. However, the inequality of payment for the nurses between the countryside and the city was the main barrier for them to return. Although some participants did not think that they would work full time in the hospital, they expressed that if part time or more flexible work schedules were available, they might think it would be very good to do some nursing job sometimes. Community health care centres appear to be the most attractive work place for experienced nurses going back to nursing.

Society needs to change their ideas about nursing. When the public feel that they really need nurses and do not look down upon nurses as if we are doing an inferior job; when people are equal and respect what you are doing; when nursing is not a job making you lose face, I would like to join community nurses or as a volunteer to take care of the neighbours. But not now, there is still a lack of the awareness of community health service. The public would like to go to the big hospital. Community health care is under-developed. (Ling)

If I return to be a nurse, I would choose a community, charity or other workplace relevant to nursing rather than work in the Grade three hospital. Although community nursing in our country has not very well developed, as I have learnt, they need more experienced nurses with independent capability of judgement and good communication skills, and the capability of prediction. They need to understand more about demographics and Epidemiology. Many people did not pay attention to prevention, but rushed to hospital when they were sick. (Bo)

The participants expressed different expectations of being community nurses, and provided very creative suggestions for the current development of community nurses in China. However, Li was the only participant who had tried to find a nursing job in a private setting or in community health care near her home, but she found it very difficult to find a suitable job.

Some community health care centres need nurses, so I am trying to find a suitable position near my home, but it is very difficult to find a job after leaving. Some private physical examination centres are recruiting nurses online. I hope I can find one near my home. (Li)

Although the Chinese government has put great efforts into developing community nurse education, community nursing courses were mainly designed for young students without nursing experience. However, new graduates are usually unwilling to work in community, which has resulted in the fact that only the new nurses who were unqualified to work in the hospitals became community nurses. As participants pointed out, currently the government encourage new recruits to be community nurses, but they not only lack nursing experience but also lack interest and enthusiasm. These strategies might waste time and resources, but could not effectively improve the quality of community care. If the government could realize the enthusiasm for community nursing among the experienced nurses who have left the hospitals, and could support their transition by offering further community

training, a great number of experienced nurses might stay and become precious nursing human resources in community care near their home. If easy mobility can be supported by the government agenda within the health care system, a realistic way needs to be found to achieve the possible win-win situation which will retain the nurses to effectively improve community health.

2.3 Nursing immigration

As a deviant case, a new Grade three Hospital was mentioned by many participants. The hospital was funded by private donation and supported by a particular government policy which is not available for other hospitals. It was regarded as the most attractive hospital for nurses to work in by many participants from different perspectives.

Most hospitals have given up holistic nursing care after trying for some period of time, but this hospital insisted on the holistic nursing model. The clinical teachers are extremely nice to interns. It offers good conditions for them to study (Bo)

The hospital implements a system of human-oriented nursing management. When a mistake happens, the director of nursing started looking first at management reasons that might have caused the mistake made by an individual nurse. (Yan)

Many nurses transferred to the hospital at that time. The hospital tries to give them free space without too much mental stress. Maybe they will be happy and enthusiastic to work with team members in such a working environment. (Xue)

The nursing specialists in the hospital are doing pretty well, such as the diabetes nurses in health care education. If a nurse can do a good job in this respect, she must be very proud of her achievement. I feel that they are very helpful in nursing development (Jie).

The hospital adopted the American style of hospital management with a relatively flexible human resource management. In a very short time, the new Grade three hospital attracted the most excellent graduates and ambitious experienced nurses with good capability in English. Many nurses were highly motivated to follow the holistic, human-orientated nursing. These nurses were expected to have a bright

nursing career. However, I was surprised to learn from the personnel department of the hospital that many nurses left the hospital in recent years.

I thought that the hospital had more advanced ideas and had very good atmosphere for our further learning. The staff were all very young. (...)I decided to leave the hospital after several months, since the hospital did not agree that the nurses could go for postgraduate education without permission. (Yuan)

Yuan left the hospital quickly to pursue her ambition of being a doctor. I began to include potential participants from a name list of 40 nurses who have more work experience and left the hospital in the last two years, which was provided by the personnel department. It is worth noting that this was the only hospital which could provide an accurate number and name list of leavers, since there is still a lack of any formal and reliable statistics on how many nurses left in other hospitals. During the sampling stage, I realised that a great number of them are working in America and Australia and a few of them went back to their home towns. Shao was a nurse with a nursing certificate who self-funded her study in Australia and came back with a master degree in nursing. She said she left nursing since when she went back to the hospital she found she had not only lost her original status within *dingbian* but also only received lower payment than her colleagues who entered the hospital together with her in the same cohort, which made her very disappointed since she originally expected her further nursing education would change her career prospects in a positive way. However, she refused to be interviewed face-to-face, and only agree to talk to me briefly over the phone, as she explained.

I did not want to say anything about leaving since I did not believe any research could change Chinese nurses' situation. I was the same as you with enthusiasm in nursing, and really wanted to improve myself in order to be suitable for the highly competitive nursing environment in the hospital. More education should increase the morale of nursing, but I am pessimistic now. If you go abroad, please do not think of going back to China, since nobody cares how much effort you made. It is worthless to improve your education in nursing. Do not think that nurses' leaving is a problem for nurses since nowadays they have freedom to choose their career. (Shao)

It seems that this hospital took the highly competitive nursing environment for granted but failed to properly reward the highly motivated individual nurses. Shao challenged the popular Chinese view that nurses' leaving should not be the problem

of individual nurses, since people have freedom to choose a proper career with more further education. Yuan further confirmed an increasing trend of working abroad among the nurses in the Hospital.

Many nurses within the Hospital who are very good in English, left and worked abroad as nurses. They did not feel that nurses would be looked down upon as doing a humble job in other countries. They thought that nursing is a career in America. (Yuan)

It was not surprising that many competent nurses in the hospital continue to go abroad. It seems that the miserable career prospects without proper rewards became the main force pushing the highly motivated and well-educated Chinese nurses to work abroad. Other participants also mentioned leavers from different hospitals who worked abroad as RN, such as the very experienced nurses, the graduates from top universities with masters' degrees, since they felt disappointed working in the Grade three hospitals.

My cousin was the head nurse in the unit of Gastroenterology; she did not think that she would have a bright future working here as she thought that the leaders of the hospital were not likely to support her further development. (Xue)

Now many people went abroad when they felt dissatisfied about the current situation, which has caused the loss of Chinese nurses. Many nurses felt that they could not expect a great future by staying in the hospital, which seems unable to retain talent. (Yan)

One of my classmates went for postgraduate education in medicine. She returned to the nursing office and took responsibility to do some nursing research, but she could not achieve anything. Then she decided to leave China for Australia. She regarded nursing as a way of living abroad. (Rao)

The most highly educated and competent nurses clearly expressed that they hoped to achieve their career expectations in nursing. While they could not reasonably expect to move around between different hospitals in China under the static nursing workforce within the Grade three Hospitals, working or studying abroad perhaps became more attractive for them. In fact, the nurses who work abroad as clinical nurses usually are the best educated nursing graduates in China, which was confirmed by several Chinese nursing immigration studies (Xu 2003, Fang 2009). An increasing trend of nursing immigration from China in the next few years has been

predicted by international recruitment (Kingma 2006), and this mainly focuses on the well qualified group of nurses with the best English capability.

3. Limited maternity leave and sick leave

The data in Chapter 4 indicates that family members' attitudes to nursing employment seem to be more important than those of nurses themselves in their career decisions, which reinforces their organizational commitment. However, there was a lack of family friendly policy to balance work-family commitment for their nursing staff in these Grade three hospitals. The hospital managers limited maternity leave and sick leave to a minimum in order to control the increasing trend of absenteeism.

Under the one-child policy, Chinese nurses usually experience only once pregnancy and maternity leave during their career life. The majority of participants encountered difficulty in their motherhood with limited maternity leave.

Li: The total maternity leave is 5 months. We have to go back to work after then, but are exempt from the night shifts for one year after giving birth.

Zhu: Another hospital reduced the maternity leave from nine and a half months to six and a half months (as Yang mentioned).

Li: Some hospitals only have 3 to 4 months now. Most hospitals are similar. They must go to work without breastfeeding time. Actually there is always lack of nurses in the hospital.

Many participants commented that the maternity leave has been compulsorily shortened year by year by the hospital administrators and the nursing managers in different hospitals. Xue had to ask for sick leave during her pregnancy.

Xue: At that time only, I asked for sick leave. My colleagues who were pregnant before me all should be on their duty until giving birth. I was pregnant when I was 30. I thought that my child was most important, since I would encounter different patients in the emergency department, such as HIV.

Zhu: Yes?

Xue: One of my colleague was pregnant one week before me. When she lifted her hand too high to change the intravenous solution for the patient, the child was lost.

Zhu: That's a pity!

Xue: We just have one child. ... I just thought... my husband also said that anyway we were not short of money, so just ask for sick leave.

Asking for sick leave has been regarded by Xue as a way to avoid the occupational hazards during her pregnancy after she witnessed her colleague's miscarriage. An unfortunate miscarriage happening on duty was experienced by another participant, Yun. After the sadness, she became worried that her working conditions could jeopardize her pregnancy again and asked to leave the Hepatitis obstetrics ward. The hospital managers were not concerned about changing the work environment for nurses who were pregnant and also did not increase the number of nurses in the ward while nurses were on maternity leave or off duty earlier for breastfeeding, which resulted in difficulty for the nurses who were experiencing motherhood to get support from colleagues and their head nurse, since their absence inevitably increased other staff's workload.

Xue: Because I initiated the sick leave, my head nurse was very angry at me.

Zhu: Why?

Xue: Because I started a bad trend, then all the nurses asked for sick leave once they were pregnant after me.

Zhu: after birth, how much maternity leave is available to them?

Xue: Just 3 months, both natural birth and caesarean.

Zhu: Just 3 months after the birth?

Xue: Yes, they must go back to work after 3 months.

Zhu: Oh, is it compulsory?

Xue: (Nod) Now, the most hateful...is...the new director of nursing. There was a nurse having twins and she could not find someone to take care of them. The director of nursing ordered her that she must be back on time.

The absenteeism strategy used by Xue was blamed for the staffing management problems of the unit. Chinese nurses normally accepted the limited maternity leave and sick leave according to the rule of hospital, since a financial punishment would be issued following their sick leave. It is unusual for nurses without good family

financial support to take long term sick leave during their pregnancy like Xue, but it was understandable that her colleagues wanted to ensure they had a safe working environment during their pregnancies. The anger from the head nurse indicated that the nursing manager had taken nurses' obedience for granted without thinking of an alternative strategy to support the well-being of pregnant nurses.

Difficulty in balancing being a new mum and a nurse working in hospital pushed more and more nurses to intend to ask for sick leave with their family support. However, asking for sick leave was more difficulty in reality than they expected, as expressed by many participants.

Nowadays it's rare for staff to ask for sick leave. Too difficult, how difficult it would be? Unless you have serious diseases that prevent you from doing your job; or you fainted on duty. Then you may possibly get permission for sick leave. However, contracted nurses dare not ask for sick leave, because if you were sick several times, you will be fired (Ling).

Warning of sacking and financial punishment was two strategies adopted to limit sick leave. Sick leave usually needed permission from the Staff Health Centre in the hospital. The health centre staff were described by many participants as the administrators who were co-operating with the nursing managers to control nurses' sick leave. As an administrator working in the Staff Health Centre, Sun gave her explanation of the sick leave.

Zhu: Someone said that it was difficult to get permission for sick leave now.

Sun: It is not like what they are saying. I think ...a little... (0.3) (Shake her head)

Zhu: Some nurses said that the Staff Health Centre only gave sick leave permission when they got agreement from their head nurses.

Sun: Certainly, it must be. I think that they misunderstand. The head nurse needs to arrange the shifts if you were sick, so I certainly need to report to her first. That is a normal process, otherwise who would be responsible for your shifts? Is it right? (...) Most of them were pregnant and do not want stay in clinical care, so they asked for sick leave. Certainly, someone was really sick.

Zhu: Have you taken any statistics of the staff health problem?

Sun: Never... (0.4) You worked in the hospital before; you knew most of them lie for the sick leave. (Laugh)

Zhu: How did you deal with the excuse for sick leave, then?

Sun: Too complex, normally the director will deal with it. I did not care since it is their business, if they are willing to sacrifice a large amount of money.

Zhu: What do you mean?

Sun: You know one day sick leave will affect many aspects of income. For example, I had one week sick leave and my salary, bonus and welfare would be greatly reduced. So nobody dare ask for sick leave. I think that without this financial control there would be more people asking for sick leave. That is the nature of people. If you have not got such control, Ha! They would think the hospital is softy!

The conversation demonstrated that the hospital managers use administrative power and financial control to limit the sick leave and maternity leave to a minimum. It was not very surprising that Staff Health Centre were not very much concerned to identify the nursing health problems or improve staff health, since there was a lack of special training for occupational health but acted more as administrators. Sun was grateful to the leader who provided the non-nursing job to her, which could explain why her view was quite different from clinical nurses' perspectives and from the position of administrators. It echoed other participants' complaints that unless the head nurse agrees or the nurses suffer serious disease, the Staff Health Centre normally did not give sick leave permission for nurses, which may result in some nurses losing the chance to recover from the earlier stages of disease. Chun was an example; she always studied and worked hard from being a nursing student to a head nurse.

I left nursing practice due to health issues. I had high fever for one week, since there was a shortage of nurses and I was too busy working hard in the ward. I did not ask for sick leave, but then haematuria came out. 6 months later, I had to leave the clinical practice in order to have a good rest.

As the head nurse, Chun worried about the shortage of nurses in her ward, so she had to insist on being on duty when she was sick. However, she missed the opportunity during the earlier stages of her illness for a proper recovery, and she suffered chronic nephritis. Eventually she had to leave nursing due to the health issue. Ling thought that she could not wait for her health status get worse.

I was only 35, but I already suffered back pain. The doctor told me that I looked like I was in my fifties due to the strain on my lumbar and shoulder muscles, everywhere. ...I decided to leave earlier rather than live with pain in my later life. (Ling)

The Chinese government normally expects that nurses should work hard even if they are sick or even when they cannot take care of their families. This expectation becomes a theme from analysis of the local and national news reports on Nurses' Day each year (May 12). A head nurse who died on duty was rewarded with the title of "excellent nurse" by the government who advocated that all nurses should learn from her (Zhou and Fan 2006). That the most excellent nurses would sacrifice their health or even their life for nursing was taken for granted by the policy makers, which inevitably had a negative impact on the morale of nurses. The government publicly praised the nurses who insisted on working when they were sick, which has resulted in a great wastage of the precious nursing resource.

Meanwhile all the Grade three hospitals have closed their child care facilities since 1998 in order to reduce costs, which created great difficulty for the nurses who have preschool children.

Zhu: Yes. Did you still have the one hour per day for breast-feeding for your daughter in her first year?

Li: Yes, I had. The head nurse did not give me one hour each day, but she accumulated the time and gave me one day off, because we normally could not finish our tasks on time and I could not leave the unfinished work to others.

Although the one hour breastfeeding time continues to be available for the staff, without child care support in the hospital, it is actually impossible for nurses to breastfeed their only child.

The hospital regarded nurses' family commitments as a personal problem. Therefore, many Chinese nurses had to look for child care help from their family.

My child was sent to my parents-in-law who live far from the City, and I could only see her when I got at least two days break, but you know we were so busy that the days off would always be separated by the managers. I could not go back to see her if I only have one day's rest. Since my child was often

sick, my parents-in-law were so worried that they thought it better I quit the job. My husband is a doctor, so his job is certainly more important than mine. (Li)

I had to pay for a nanny to take care of my child, but it is not easy to find a good nanny. (...) My husband already has several successful companies and he thought that I could just look after the family and be relaxed with my daughter. (Qun)

Traditionally, Chinese parents usually would try their best to support child care for the young nurses. But because most of their parents live far away from the city, the traditional family support is not always available in modern Chinese society. It is quite common that, if they could not afford to pay for a nanny to take care of their only child, the nurses chose to live with their parents, or sent their child to their parents, if they could not come to the city and live with them. Many nurses had to separate from their only child at a young age. But as Ting said, “*Lots of nurses left because they could not look after the family*”. Nurses made individual efforts to find family and social supports to balance their work and family commitments, but this increased the financial burden and mental stress for nurses who were the mother of a young child.

I had no time to look after my family and I did not think I had a good quality of life as a nurse. I was exhausted when I went back home after the shift, so I was too tired to play with my kid and I just wanted to fall asleep. (Chen)

It would be perfect if you have a good career and also take good care of your family and child. No matter how capable you are, if your family is unhappy, you still would not be a successful woman. The director of nursing warned us that if we left the job, our husbands would look down upon us and our marriages would be unstable. However, I doubted if we continued to dedicate ourselves to the job, would the marriage be stable? I did not think that I was happy at that time. I always complained about my job at home, but my husband did not understand, and I would become more irritated. After quitting the job, I felt physically and mentally released. (Xue)

Many participants felt guilty as a woman and chose to take care of their only child and family. The participants’ desire to be independent as a woman was taken for granted by the nursing managers without concern for their desire for the family-work balance. It seemed that the managers still held their generation’s view of the gender discrimination. However, several participants mentioned that since nurses could not

balance family and work life, some young nurses currently had to face a relatively difficulty situation to get married.

In the past, there was a popular view that a nurse would be a good mum and wife for the family, so nurses usually made a good marriage. Now nurses do not have this advantage to change their social status by marriage. Along with the social development in the 21st Century, the work employment market has provided wider career options for women who get higher education. Most female white collar workers have more regular work and leisure time than nurses, while young nurses in Grade three hospitals could not even join in a normal social life at the weekend and on public holidays. Some of them find it difficult to find a husband. (Chun)

The perception that nurses could not balance family life and work commitment not only negatively impacts on their marriage, but also influenced their social life. Many participants expressed that they felt ashamed to be recognized as a nurse in their personal social life.

Qun: When people asked me what I was doing, I told them that I worked in a hospital. If they asked me about my job, I only told them that I worked in the hospital.

Zhu: Why didn't you say you worked as a nurse?

Qun: Then, they might ask, which hospital I worked for. I was willing to tell them the hospital. The hospital is a good hospital. Then (they asked) 'are you a doctor or a nurse?' I did not like to hear that question, although I had to answer that I was a nurse after being asked. Truly, they would add the words 'Oh, a nurse, nursing is very hard'. Everyone will say this. (Qun)

The fact that nurses work hard has been widely acknowledged by Chinese society, but their value to society is not well communicated and respected by the public. It would discourage the young generation from choosing nursing as their career. The disadvantage of working in clinical care on a social life and family might discourage the parents from sending their children to study nursing and work hard in the future as most of them are the only child in the family. Nursing students' recruitment for higher education has currently experienced a difficulty. If such circumstances continue to exist, it might predict that a greater challenge of nursing shortage in the future will become a serious social problem in China.

Without positive organizational and social support, nurses also gradually lose their family support for their work commitment, since their family members usually do not understand what nurses' encounter in their work and seldom value nurses as professional personnel.

I would say many nurses were looked down upon by their family: "You are just a nurse in the hospital, and a daughter-in-law at home." (Ting)

A head nurse told me that, one day of the Chinese New Year, she was busy on duty rescuing an organophosphorus pesticide poisoning patient. When she went home that night, her husband was angry since she had not prepared to celebrate the New Year's Eve. She was very sad. She had saved a life and came back home exhausted, but nobody understood her. With family support, it would be better. If not, then... there are so many different pressures. I feel that is really suffering. (Xia)

I was proud of myself that I could try my best for patients with my knowledge and skills. But my husband said that I worked in the hospital, but I couldn't even ensure my own health under the unlimited extra work hours. "You are so busy running around the unit like an unskilled worker" ...He did not understand my value as a nurse. He thought that it was more valuable for me to take care of my child and family and to support his successful business. To be honest, he is not working as a nurse and did not feel the suffering of patients. (Qun)

The reality of struggling with the work and family conflict prevented them from being proud of themselves as nurses both in the workplace and at home. Concerning the quality of family life and well-being of nurses, nearly all participants get support from their family to leave nursing career.

As a matter of fact, if my family did not support my leaving, I had never thought of leaving. My parents thought that I worked too hard and I should quit the job. (Ting)

My husband thought that I'd better look after the family and he also hoped that I needn't work so hard. My parents thought that the ideal job for a woman is that I can have enough time to look after the family and educate the child. (Xia)

My parents had changed their ideas a lot and thought it was normal for me to quit. I still felt guilty that I gave up my career and I did not do any job, then I decided to have my second child, so that I could give myself the excuse that I had to leave the hospital without choice (Laugh) (Ling)

Five of my classmates resigned their nursing jobs for their children. (...)Another child is a special gift for my resignation. If I still worked in the hospital, I could not have the second child. (Xue)

It seems not easy for participants totally to give up their work commitment after so many years training and practice in nursing. It was interesting that Ling and Xue said that having a second child is a compensation for their leaving the organizational control. In recent years, the dramatic economic development of China has enabled more and more nurses' families to be able to afford to support nurses to leave the organizational control especially for taking care of their only child in the family. Limited maternity leave and sick leave might temporarily reduce absentees, but if the hospital administration and health policy continue to ignore their nursing staff family commitments and do not change the management strategy, there would be a danger that more Chinese nurses would directly leave their nursing career with their family's support in the future. The full time work schedule without flexible work hours and limited maternity leave policy for nursing currently faces great challenges. Without positive prospects for the future from the hard work, participants generally accepted themselves as a woman who should take care of their family and abandon their value as nurses.

4. Summary of 6th data chapter

Due to the lack of reasonable nursing workforce mobility between units, hospitals and countries, Chinese nurses do not have freedom to find the most compatible nursing practice environment, where they could expect to achieve their best personal and professional development. Chinese nurses are acutely aware that leaving nursing practice usually means permanently leaving a nursing career, while the hospital managers emphasised that leaving is an individual loss rather than an institutional problem. The organization not only used financial punishment to limit sick leave and maternity leave to a minimum, but also set up the compulsory contract which reconfirms the legal position of the hospital and forces the nurses to accept unfair treatment for staying or penalties for leaving without dispute. The ideal workplace becomes a trap to keep some nurses staying by adjusting their expectations of

nursing, which causes great invisible wastage of nursing. When individual nurses lost hope of achieving their individual expectations in their nursing career, this empowered them to leave the powerless status of being a clinical nurse. Leaving nursing practice was interpreted by participants as the way to pursue personal freedom.

So far we have seen how the Chinese nurses entered and worked as clinical nurses in the ideal workplace (Chapter 3 and 4). The participants further described their frustration at being unable to ensure the safety and quality of care (Chapter 5) under medical dominance (Chapter 6) and insufficient managerial support (Chapter 7). Throughout the interviews, the participants expressed how they expected to do a good job in the beginning of their career with organizational commitment (Chapter 4) and how they struggle to balance their work and family commitment, but they chose to leave nursing practice as a way to pursue personal freedom from the organizational control (Chapter 8). Before drawing the ideas together for further discussion of the relationship between the conceptual categories, there is a need to review the summary of the themes, main categories and core categories that have been presented in each of the data chapters (see p86 Table 7).

Chapter 9 Discussion

This chapter draws together all the analysis from the previous data chapters and identifies four nursing career behaviour patterns by illuminating the interrelationship of the two core categories. Discussion follows to explain how the data are conceptualised into subcategories and core categories. Then the conclusion progresses towards a theoretical explanation and understanding of nurses' leaving nursing practice. The implications of the study for educators, hospital managers and policy makers are recommended based on the understanding.

1. Drawing the threads together

The two core categories, “*Mismatched Expectations: Individual vs. Organizational*” and “*Individual Perceptions of Power*” (Table 7) emerged from the analysis of the experiences and perceptions of participants from entering to leaving nursing practice. These two conceptual categories have been critical in affecting how nurses perceived their situation of being a nurse, and consequently orientated the individual towards leaving clinical care based on their experiences and the exercise of power at the individual and organizational levels within the Chinese health care system.

The interrelationship of the two core categories is illustrated through a cross-tabulation (Table 7). The idea of using the cross-tabulation was inspired by Glaser, who suggests that when the analyst uses relevant and grounded, data determined distinctions with logical elaboration in a cross-tabulation, it “helps achieve the goal for theory of parsimony of concepts, while at the same time richly densifying the theory” (Glaser1978:64). However, as I have previously discussed the theoretical debates on grounded theory in the research design chapter, I raise a caution that the aim of parsimony of theory may lose some explanatory power in the conceptual categories. I agree with the suggestion from some experienced grounded theory researchers that the importance of study is not to discover a theory, but to assist in

understanding the issues under investigation (Heath and Cowley 2004). Melia (1981) also advises that the importance of constant comparative analysis lies in the explanatory power of the conceptual categories. Therefore, the cross-tabulation in this study is used as an analytical device, which serves as a strategy for handling data. When the interrelationship between the two core categories is made explicit, it offers a theoretical means to understand why nurses voluntarily leave nursing practice and how their employment decisions have an impact on the safety and quality of health care in China.

Table 8: The interrelationship of the two core categories

		Individual Perceptions of Power	
		High	Low
Mismatched Expectations: Individual Vs. Organizational	High	Voluntary Leaving by choosing to leave nursing practice	Passive Staying by accepting nursing as just a job for life
	Low	Active Staying by pursuing nursing as a life career	Adaptive Staying by learning rules and focusing on tasks for “fitting in”

Based on the data-determined “high” and “low” distinctive dimensions of core categories, the cross-tabulation reduced nursing career behaviours and consequences of employment decisions into four typologies (Table 1). Each typology emphasises a behaviour pattern, not a personal pattern, although a person may be considered to be engaging in a type of behaviour. The four behaviour patterns imply a continuing nursing employment process, which include: **Voluntary Leaving, Active Staying, Adaptive Staying and Passive Staying.**

The first behaviour pattern of **Voluntary Leaving** is determined by “high” in both categories. It indicates that the higher the mismatched expectations of nursing between individual nurses and the organization, and the higher extent of power they perceived, the more they are likely to voluntarily leave nursing practice.

The second behaviour pattern of **Active Staying** is also characterised by “high” individual perception of power. It indicates that when the individual and organizational expectations of nursing are closely matched, and the higher extent of power they perceived, the more they are likely to pursue nursing as a life career.

The two behaviour patterns **Adaptive Staying** and **Passive Staying** are characterised by “low” individual perception of power. **Adaptive Staying** has concordance with the concept of ‘fitting in’, which was first described by Melia (1981). The study provides a comprehensive understanding of nursing socialization from a student nurse’s perspective. It constitutes a major part of the students’ behaviour, which means that students cannot integrate education and service segments in their transient stage, but learn how to go through their educational and clinical training separately. Although the data was drawn from hospital-based learning nursing students’ perspectives before the project 2000 in UK, the data from my study confirmed that the Chinese nursing students and new nurses chose to adapt their individual expectations of nursing and continue to “fit in” the hospital criteria of being a good or qualified new nurse. This behaviour pattern of **Adaptive Staying** does not necessarily mean that the degree of mismatched expectation between individuals and organizations is actually low among the new nurses, but it means that there is lack of sufficient time and space for most of them to distinguish the mismatches in the early stages of their nursing job, and they are very aware of their lack of power to pursue their individual expectations of nursing. Therefore when they could not receive proper supports from clinical supervisors and managers on time, they just “fit in” to the organizational expectation in the context of their clinical practice by learning rules and focusing on tasks. The data of my study in Chapter 5 further indicates that when some new nurses continue to “fit in” for an **Adaptive Staying**, they acted

towards patients with dehumanized attitude, which have caused patients' suffering. The extent of individual perception of power might still be low when nurses continue to practise over time. When they realise a high degree of mismatched expectations between individuals and the organization over their practice, they compromise their individual expectations of nursing to meet the organizational expectations and accept nursing as a job for life. In this way, they are engaging in the **Passive staying** behaviour pattern.

The four behaviour patterns in the cross-tabulation demonstrate that, nursing career behaviour and employment decisions could be explained by the degree of mismatch between the individual and organizational expectations of nursing; and the extent of imbalance of power the individual nurses perceived in being a clinical nurse within the organizations. The interrelationship between the two core categories indicates that, while nurses stay but do not have empowered engagement in active staying, wastage may occur when experienced nurses engage in passive staying and potential wastage may happen when novices continue an **Adaptive Staying** without timely and proper supervision and management support.

By further illuminating the interrelationship between the two core categories which characterise the different patterns of behaviour and the consequences for employment decisions, the following sections discuss why nurses voluntarily leave nursing practice, and how nursing wastage occurs alongside a serious nursing shortage in China. The main categories and themes (Table 7) that emerged from the analysis in each data chapter offer suggestions about what to look for and develop a theoretical understanding based on the reality as it exists.

2. Mismatched Expectations: Individual vs. Organizational

When individuals join the nursing workforce, they not only bring their individual expectations of nursing but also they are required to meet the needs of patients under

the organizational expectations. The core category “Mismatched Expectations: Individual vs. Organization” is constituted by the following three subcategories.

- Entering nursing with unrealistic expectations
- Working in the ideal workplace
- Losing confidence in the safety and quality of health care

These three subcategories are grounded from the data which has been presented in each of the three data chapters. Data chapters 3 and 4 have articulated the participants’ pre-entry expectations of nursing and their employment experiences of working in the ideal workplace in China. Data chapter 5 indicates the perception of the high risk of clinical practice that has negatively impacted on participants’ faith in nursing, since it goes against their expectations of taking professional accountability for the safety and quality of care as clinical nurses.

2.1 Entering nursing with unrealistic expectations

In chapter 3, “Entering nursing with unrealistic expectations” emerged as a subcategory from two themes “Choosing nursing under collective expectations”, and “Restricting realistic expectations in nursing education”. The finding supports the argument that the reasons why nurses entered the profession should be considered in association with the reasons why nurses leave the profession (Duffield, O’Brien and Aitken 2004).

However, the finding of the study may surprise some Western scholars: other than voicing concerns over the collective expectations of nursing, the Chinese nurses rarely talked about their initial choice of nursing as the desire to “care for” or “help” others, which has been widely regarded as the accepted attitude to nursing in nursing literature (While and Blackman 1998, Mills and Blaesing 2000, Brodie *et al* 2004). Compared to the Chinese nurses, many western nursing students enter nursing education for reasons related to personal interest or because of a caring intuition (Mackay and Elliott 2002, Brodie *et al* 2004). However, the differing pre-entry

expectations and cultural perspectives of nursing students should not be simply interpreted as comparative data.

The retrospective experiences of the participants indicate that different Chinese generations chose nursing based on the social family economic situation and the health care insurance coverage along with the social-economic and educational development in the past three decades. Under an inequality of health care coverage and an imbalanced economic development between urban and rural areas within Chinese society (Anand *et al* 2008), nursing was regarded as a safe job for young woman, a privilege to access free health care for family and an appealing educational chance for social mobility. The earlier students, who got free nursing education, were more concerned with reducing the family budget burden for their siblings' education. The self-funded nursing students were more concerned about the privilege of health care for family, while recent nursing students, from the one-child generation, were more personally concerned with the reality of themselves, and might treat nursing study as a ticket to other careers. Although the Chinese nursing students' selection requirement has undergone a historical change since 1978, it is not surprising that many nursing students involuntarily choose nursing under collective expectations of nursing in China, which has been historically taken for granted in Chinese nursing student enrolment. Data chapter 3 shows that current Chinese nurses were predominantly women from rural areas or small towns with farmer or lower working class backgrounds. The participants' view, which is widely held in China, is that there is no need to worry about nursing shortages in China because plenty of girls from rural areas are waiting to enter nursing.

Many researchers focus on nursing wastage from the perspective of nursing educators, because the high rate of nursing students' turnover in Western countries has caused great educational and human resources wastage from public financial investment (Kotecha 2002, Lavoie-Tremblay *et al* 2008, Pellico *et al* 2009, Rheume *et al* 2010). In the UK, studies by the National Audit Office (NAO 2001) indicate that student dropout rates in some institutions are as high as 40%, and the student

nursing attrition rates are between 17 and 25%. These studies are mainly concerned with avoiding students leaving their pre-registered education by providing support in the educational settings. However, compared with a relatively high rate of nursing students' turnover and a declining trend of young people joining the nursing workforce in most developed countries (Duffield and O'Brien-Pallas 2002), the number of young people joining nursing study in China has statistically increased in recent years and the data in chapter 3 indicates nursing students attrition appears not to be a problem in China. Although many Chinese nursing students involuntarily chose nursing study, they rarely give up their nursing study because of restrictions in the current education system and the highly competitive employment market in China. These facts may be regarded as good news by current nursing workforce researchers. However, my study suggests that the relatively low rate of nursing student turnover in China should not be simply interpreted as good news by the Chinese educators and the government. The interpretation of the current increasing statistical number should be viewed with caution according to the participants' view of their recruitment and educational experiences related to the historical development of nursing education in China.

Since 1998, China has launched a major expansion of higher education with the integration and growth of medical and nursing schools within comprehensive universities (Anand *et al* 2008). The different levels of nursing education institutions moved to higher qualifications of nursing education in a very short time. However nursing students currently need to pay the similar tuition fee as students of medicine at the same level of education in China since the Chinese government cancelled free education for nursing in 1995. This has resulted in the educational institutions facing dramatically fewer qualified applications for nursing study.

According to the description of the participants in the study, the study found that the education institutions had adopted three strategies to increase the number of nursing students. Firstly, the reality of being a clinical nurse was deliberately blurred in the student recruitment and education processes by the nursing educational institutions,

which particularly focus on the 1st and 2nd academic levels of students in order to attract well qualified students into nursing higher education. Secondly, transferring students into nursing study without the student being truly willing has been adopted as a main strategy to ensure the numbers of nursing students within the university. Thirdly, the universities set relatively low entrance requirements for higher education in nursing in order to increase the number of students, so entry to nursing is regarded by some students as a “ticket” for other occupations. China is currently under the pressure of high unemployment in the labour market, there are not many alternative employment choices available for young people, and a higher education degree is normally required as a basic qualification for a decent job. Therefore, Chinese parents usually provide tuition fee support for their children’s full time higher education, especially for the current one-child generation. It is understandable that although many Chinese nursing students enter nursing for different reasons under fierce competition for higher education in China, they normally complete nursing education according to their parents’ wishes without quitting.

Furthermore, the unrealistic expectations of nursing continue in their nursing study, as the data indicate. The Western literature found that the main reason for nursing students’ attrition was the unexpected high academic requirement (Brodie *et al* 2004), but the evidence in this study confirmed that the majority of leavers graduated with excellent school performance. The data shows that they were particularly dissatisfied with the strict and narrow requirements of nursing study, which not only negatively influenced participants’ enthusiasm in their pre-registration learning, but also continued to erode their motivation for post-registration learning. Many participants commented that the nature of nursing work is not clearly recognised nor fully valued in nursing education. The participants generally came with a vague impression that nurses may be less knowledgeable than doctors through the interaction with their peer medical students and the teachers with a nursing and medical background. Chinese nursing higher education reform is currently under pressure to improve academic levels following developments in medical science. There is a lack of a clear vision and curriculum design for the different levels of nursing education, which has resulted in great frustration for the students at

bachelor's level, particularly amongst the most excellent nursing graduates who expected to be equal to the physicians in their clinical practice, as the data indicates.

Nevertheless, compared with less appreciation of their nursing teachers, the majority of leavers in my study generally appreciated the support from clinical supervisors in their work placement, which reduced the theory-practice gap to a certain extent and most of them were keen to support their inexperienced colleagues in their daily practice as clinical supervisors. Chinese nursing students were more likely to regard the clinical supervisors as role models. The evidence supports Maben's argument (2008) that good supervisors can reduce the theory-practice gap. However, several participants mentioned that their supervisors suggested to them, and they, in turn, also suggested to their students, an early leaving of their nursing career. The study indicates that although good mentorship may reduce to a certain extent of the theoretical-practice gap by giving technical and caring support, there is a caution that the clinical supervisors with negative attitudes to their nursing career may undermine the morale of nursing through the trust relationship with their students and junior staff, which implicitly or explicitly encourages nursing students towards leaving. In this way, the clinical supervisors who engage in the behaviour pattern of **Passive Staying** may cause a further wastage, which negatively impacts on the stability of the potential nursing workforce.

The study suggests that the current Chinese nursing enrolment and educational strategies have not effectively helped the nursing students to clarify and establish realistic expectations of nursing. As a consequence of entering nursing with unrealistic expectations, the evidence of my study confirmed that not only did some nursing students with a higher level of education simply leave clinical care for other more prospective careers than nursing after graduation, but also some students with a lower level of education delayed joining in the real nursing workforce or underemployment. These educational recruitment strategies have been criticised by some participants as an unnecessary wastage of nursing educational investment.

However, there is a lack of reliable statistics to indicate how many inactive nurses there are in China.

Only a few researchers have conducted surveys to study the inactive nurses who are outside nursing in Australia. Duffield *et al* (2004) reported that nurses who were well qualified and skilled were capable of making the transition to a range of other careers when they decided to leave the nursing profession. Therefore, they optimistically recommended choosing nursing as a stepping stone to future careers. Based on Chinese leavers' experiences, the study suggests that the recommendation of Duffield and her colleagues might attract more students into nursing to ensure the survival of the educational intuitions, but it would inevitably increase students' unrealistic expectations of nursing when nurses were inspired to choose nursing as a stepping stone for other careers rather than actively staying in a nursing career. The majority of participants in this study strongly recommended that, in order to avoid the educational wastage, nursing students should be encouraged to make a free career choice by being fully informed of the nature of nursing work. It suggests that the student entering nursing with realistic expectations of nursing is important to keeping a stable nursing workforce during their nursing career.

By examining the participants' employment experiences of working as clinical nurses, the following section continues to explore the reasons for and consequences of the massive difference between education production and absorption of the nursing workforce in the current Chinese health care system.

2.2 Working in the ideal work place

In chapter 4, the notion of "working in the ideal workplace" expressed by the participants has illustrated how the organizational expectations of nursing effect Chinese nurses' faith in their employed hospitals and the nursing profession. It emerged as subcategory from three themes: "Entering the ideal workplace", "Committing to the organization", and "Struggling with the nursing professional identity".

The evidence indicated that although the participants left nursing practice and none would like to work in Grade three hospitals as a nurse again, the majority of them felt proud of working in these ideal workplaces in the beginning of their career. Chinese nurses regarded the Grade three hospitals as the ideal workplaces, since they could earn a much higher income and were presumed to have more chance to have an up-to-date advanced nursing career than if working in low grade hospitals in the rural area. The findings indicated that when the participants successfully enter the ideal workplace, their pre-entry expectations of nursing seemed to be well met within the organizations. However, the hospital managers have taken over-supply in the recruitment pool for granted under the high pressure of Chinese employment market. The new recruits had to accept discrimination and unfair contracts with unequal pay in order to obtain a position in the ideal workplace. The highly competitive selectivity in the ideal workplace implicitly forces the well-educated nurses to accept organizational identity rather than professional identity. The majority of participants expressed that they expected to do a good job in their employed hospitals with a strong organizational identity and commitment. However, as the data indicate, the participants struggled in matching nursing identity with the organizational expectations. It seems that the confirmation of pre-entry expectations may help the participants establish an earlier organizational commitment, but the organizational commitment was not always associated with a high level of satisfaction, as current literature indicates (Wagner 2007, Lu *et al* 2007).

As many participants commented, what was delineated by such strict recruitment requirements and procedures might not be functional necessities for effective nursing care, since these hospitals recruited the most qualified nurses but did not effectively employ with clear role boundaries and effective skill-mix team work. Lack of role boundaries and role insufficiency were also identified as the factors that had the highest association with occupational stress among Chinese nurses who are working in Grade three hospitals located in the north of China by Wu *et al* (2010). Wu *et al* suggest that it is necessary to improve nurses' knowledge and skills by providing

them with effective education programmes in coping effectively with the increasing job demands, thereby changing role boundaries and role insufficiency and reducing occupational stress. The evidence from my study did not support their view that education intervention could resolve the issues. It is too easy to blame nurses for their educational preparation without an understanding of the political climate value of nursing within the organizational expectations.

Firstly, rational nursing employment decisions and role boundaries rest on the hospital administrators, and these decisions are mainly controlled by one or two key administrators in Chinese hospitals, particularly the presidents of the hospitals. It is normally true that only a person who has demonstrated an adequate training is qualified to be a member of an administration according to Weber's (1978) classic bureaucratic view¹⁶. However, there is wide criticism that Chinese hospital administrators normally have a medical background without proper training in management (Wu 1997, Pei *et al* 2002). Based on their medical understanding of nursing, the priority of acute treatment and their pressure to meet the profit target, Chinese hospital administrators emphasise advanced techniques, medical expertise, and luxurious hotel-style service facilities in order to compete with other hospitals to attract more patients (Pei *et al* 2002). Although the number of doctors is historically much greater than the number of nurses in China (Table 1), they continue to recruit more highly qualified medical experts but strictly limit the number of nursing staff. Although the Chinese health ministry advocates that patients must be cared for only by qualified nurses and plan to cut all unqualified care assistants, the number of nurses is strictly limited, although participants in this study reported a nursing shortage in the clinical setting. Current recruitment at these hospitals reserves a majority of *dingbian* for new medical staff and only provides *dingbian* for a small percentage of the nursing graduates with a bachelor's or higher degree. Meanwhile using bonus and welfare redistribution has been regarded as an effective method to control nursing staffing and cut the budgets of hospitals., The hospital administrators

and nursing managers were granted certain authority to differentiate the financial rewards to a certain extent to control the nurses' obedience or to punish disobedience according to their managerial preference, which enabled a greater exploitation of the available nursing labour force. Without an open and transparent decision-making process and discussion with the staff, these strategies not only increase frustration among nurses but also have a negative impact on effective team work during clinical care, as the data indicate.

Secondly, nearly all participants confirmed that the current serious understaffing and unlimited workload has forced available nurses not only to have to do extra work hours but also to sacrifice their off duty time as the hospital requires without extra reward. The reality is that they must concentrate on getting the work done by following organizational rules and procedures, which has resulted in the fact that the well-educated and qualified nurses in the Grade three hospitals continued to struggle with their professional identity under mismatched expectations of nursing between the individuals and the hospitals. According to Etzioni (1964), professionals are committed first to the goals of their profession and second to the goals of the organization. However, the data indicated that, in perceiving the fact that the acute treatment did not improve the quality of patient's life, nurses intended to dehumanise the individual needs of patients and focus on tasks rather than human centred holistic care. As a consequence, role insufficiency occurs since nurses who expected to care for patients with a humanistic orientation are instead expected to focus on tasks implemented under the doctors' orders by the hospital administrators, which has a negative impact on the morale of the nursing workforce. The priority of acute treatment under the Chinese hospital management and health care system has restricted the development of nursing professional ideals and clinical practice. The majority of participants expressed an unresolved dilemma when they could not meet the requirements of both hospital and patients as a clinical nurse.

¹⁶ According to Weber's (1978) legal rational theory, the root of the authority of the bureaucrat is his knowledge and his training, not that these replace legislation, but his command of technical skills and knowledge is the basis on which legitimisation is granted to him.

Thirdly, hospitals are characterized as professional organizations with divisions of labour (Etzioni 1964), with multiple goals including health services, teaching and research. As the data of the study demonstrated, some well trained nurses remained employed as nurses but had to do non-nursing jobs such as office secretary, typist, clerk, accountant, and cleaner. Nurses, as coordinators between the hospital administrators, medical professionals and the patients, bear multiple responsibilities for caring, managing, coordinating, researching, teaching and supervising the delivery of health care, and serving as the acting manager in the physician's absence. However, as Allen (2004) argues, the ideal of nurses as mediators in the health care system is taken for granted by the managers which places nurses in the middle of a "tug-of-war" (Freidson 1970) without effective solutions or fully acknowledging their contribution. My study supports McGrath's (2006) argument, that the holistic understanding of nursing creates the potential for a workload that makes it impossible for nurses to define their roles with clear boundaries.

According to Biddle (1979), individuals are able to restructure expectations for their positions or roles to adjust role strain¹⁷, which include "reduced involvement" and "role distance"¹⁸. Some participants commented that many colleagues who intended to leave but had to stay regarded themselves as "waiting for retirement". They distanced the ideas of human centred holistic care by focusing on tasks, and stopped active professional learning, but just passively followed the hospital rules in order to convince themselves to tolerate the mismatched expectations. The data show that nurses withdrawing their active involvement in the workplace not only negatively affects nurses' well-being with low-esteem but also causes patients who received dehumanized care to suffer. The "**Passive Staying**" career behaviour occurs when nurses have a low perception of power to deal with the mismatched expectations.

¹⁷ Persons who experience stress associated with positions or expected role are said to experience role strain (Merton 1968).

¹⁸ Involvement concerns the degree to which the person invests effort or is organically engaged in role performance; role distance means defence against the appearance of role involvement through casualness, confidence or humour (Biddle 1979:326).

It needs to be mentioned that the majority of participants were the brightest students with the best educational qualifications and had gone through strict selection procedures. Once they committed to the organization and concentrated on the current job, they usually not only tolerated the difficulties in meeting the organizational expectations but also actively tried to achieve their individual expectations of nursing. The study found that most participants were proud of doing a good job, since they could make a difference to patients in their daily nursing practice. It is the patients who make the job meaningful to the nurses in the initial stages of their nursing career, such as the patients' trust and compliments. These participants wished to prove the value of nursing and tried to relieve the suffering of the patients by their professional care. The data show that the majority of leavers were highly motivated to study and work harder and very soon became the key staff in their hospitals. Most of them acted as team leaders before they left. They did not accept work just for life like the passive stayers.

2.3 Losing confidence in the safety and quality of health care

A perhaps surprising finding of the study is that nearly all participants, both experienced and inexperienced nurses, lost confidence in patient safety and quality of care, which was presented in chapter 5. It emerged as a main category from three themes: "Perceiving the risk in clinical practice", "Recognising the organizational barriers to safety" and "Failing to meet expectations of patients."

The study found that under a blame culture and a lack of transparent organizational risk management, whether the participants personally experienced adverse incidents or witnessed their colleagues' suffering after they encountered accidents, all of them worried that accidents would happen to them and the safety of patients was out of their individual control. The majority of participants who were experienced nurses expressed that although they had made a great contribution to maintaining safety and quality of care through their hard work, and supporting inexperienced colleagues, they still could not ensure patients' safety in the high risk work environment by their

individual efforts without proper risk management and support in the organization. Perception of the high risk of clinical practice has negatively impacted on their faith in nursing, since it goes against their expectations of taking professional accountability for safety and quality of care. This often became the principal force in making their decision to leave nursing practice.

The relationship between nurses' leaving and perception of safety was well supported in literature (Clarke 1999, Aiken *et al* 2003, Hart 2005, Kruger *et al* 2006). Kruger *et al* (2006) identified that personal competence is a critical determinant of patient safety. Aiken *et al* (2003) studied the relationship between hospital nurses' educational levels and surgical patient mortality. They found that, with higher proportions of nurses educated at the baccalaureate level or higher in hospitals, surgical patients experienced lower mortality and failure to rescue rates. The limitation of the main literature is that the solutions are mainly given from an educational perspective, and believe that the issues of safety and retention will be resolved by the improvement of levels of nursing education. This view was taken for granted by the Chinese hospital administrators and nursing managers. As a compulsory criterion of quality health care, all current clinical nurses under the age of 45 in these hospitals must obtain a bachelor's degree, which was regarded as the one criteria of good quality of care. The evidence of the study has indicated what is important for the hospital credentials is the level of qualification obtained and not the content and positive value of the education the nurses gained. My study did not argue the necessity of educational improvement for safety practice. However, the findings already pointed out that even though the hospital recruited the best educated nurses, they were not effectively employed in their best capability because of the shortage of staff and a lack of effective skill-mix team work in the organization. Therefore, I argued that, by solely emphasizing an educational intervention for safety and quality issues, Chinese nursing workforce planning might become what Davies (1995) called a "high intake and high wastage model" .

In a study of patient safety, Smith, Pearson and Ross (2009:233) state that “a caring nurse is more than willing to promote patient safety”. While McGrath in her PhD study found:

It is often those with a powerful sense of commitment to caring for others who find the strength to leave nursing and seek satisfaction in other fields of work (McGrath 2006:3).

McGrath has not fully explained why the nurses commit to caring but seek satisfaction in other careers rather than in nursing. The notion of caring has not been particularly mentioned by Chinese nurses in my study, while the majority of participants who are experienced and competent nurses thought that a good nurse ought to be more effective in improving of patients’ health by providing a safe and high quality of care. My study suggest that the leaving decision is determined neither by the individual commitment to caring nor safety, but it is an interactive decision making process, which heavily depended on whether the individual and organizational expectations of nursing are aligned towards the safety and quality of health care.

At the health care organizational level, organizations with “patient safety as first priority” have good reputations in society and so are highly acknowledged (Jones and Redman 2000). However, the findings of my study confirmed that “patient safety first” in Chinese Grade three hospitals is not mainly a result of the goals of managerial strategies. The participants’ values, attitudes and beliefs regarding safety in this study further support a reciprocal interactive view of patient safety culture from a “bottom-up” perspective, which was proposed by Feng *et al* (2008). It provides a theoretical perspective to understand the patient safety culture from four sub-dimensions: system, personal, task-associated and interaction (Ibid). Based on their content and dimensional analysis of patient safety culture in nursing, Feng *et al* (2008) further suggested considerations of the safety culture from the reciprocal relationships among nurses’ perceptions of the feasibility of “patient safety first”; nurses’ daily practice towards this goal within power relationship; the presence and quality of control systems to support nurses’ attitudes and behaviours towards patients safety. However, the study included nursing literature mainly from the USA

health care system, which might not adequately capture the complex multidisciplinary nature of patient safety culture in the Chinese healthcare system.

The Chinese health care system has gradually transferred from a planned to a market economy. Payment for health service policy has shifted the hospital management towards a profit orientation since 1979 (Hsiao 2008). The “goal displacement” which is described by Etzioni (1964) provides a very helpful start to understanding the organizational expectations of nursing in these Chinese hospitals:

It arises when an organization displaces its goal-that is, substitutes for its legitimate goal some other goal for which it was not created, for which resources were not allocated to it, and which it is not known to serve. ... The mildest and most common form of displacement is the process by which an organization reverses the priority between its goals and means in a way that makes the means a goal and the goals a means. (Etzioni 1964:10)

It could be argued that such “goal displacement” happened when Chinese hospitals’ prime expectation became to achieve the highest profit rather than focus on the goals they declared for public health (Pei *et al* 2002, Yip and Hisao 2008). Merton (1968) notes that an extreme case of goal displacement occurs when the employees never comes to a decision of their own making because they are so concerned with following organizational rules, that this occupies their entire attention. As Merton (1968) warns, when nurses continue to follow the rules and the institutional procedures as a routine and their attitude to patients is inefficiently depersonalized, the client becomes “invisible” in their daily practice. My study has demonstrated that it is detrimental for patients’ health if the nurse takes the organizational expectations for granted and ignores professional judgement, which greatly impacts on nurses’ well-being and the safety and quality of health care for patients. The findings of my study further suggest that the more serious the goal displacement, the higher the degree of mismatched expectations of nursing between the individual and organization in the current nursing workforce.

Many participants commented that the patients’ actual rights for safety and quality have been compromised by understaffing. The relationship between staffing and

safety has been well documented (Aiken *et al* 2001, Aiken *et al* 2008, and Duffield *et al* 2011). However, the Chinese policy makers and the hospital administrators are reluctant to link safety and cost efficiency issues with nursing shortage without proper evaluation of nursing staffing. Currently, the unreliable statistics of nursing staffing provided by the hospitals have already caused concern to the government (MHPRC 2011b). In order to improve safety, frequent and regular assessment and monitoring were organized by the hospital administrators and by local, provincial and national health authorities in the different levels of safety inspections. From their personal experiences involving inspection, many participants doubted whether the bureaucratic inspection approach could effectively find the organizational barriers affecting safe health care. Some participants pointed out that the strategies used by the hospitals for the inspection might protect the organization rather than protect patients. A participant said that she felt ashamed that she and her colleagues were forced to ask for the patients' cooperation in order to get a high rate of patients' satisfaction evaluations just in order to pass the evaluation of quality health care. There was a lack of sufficient educational, organizational, political and legislative support for Chinese nurses to raise and resolve safety issues. When they felt they could not assure the safety and quality of health care by their efforts, some of them felt ashamed to work as a nurse and most of them lost the motivation to stay in a nursing career.

Compared with the more experienced participants, the participants who worked for less than 3 years did not directly comment on the safety issues in their practice. However, the safety issues were indirectly illustrated by their experiences of being evaluated as "a good nurse" in the beginning of their nursing practice, both as a nurse intern and a new nurse. Within the understaffed work environment, the organizational criteria of being a "good nurse" were emphasised for the new nurses. The sooner they got used to doing the job independently, the better evaluation they would be given by the head nurses and colleagues. The new nurses expressed that they had tried their best in practice and wished to be recognized as excellent nurses. However, they have to face a "reality shock" due to the lack of preparation for the organizational expectations of nursing. In talking about their experiences as interns

and new nurses, many participants described how they suppressed their scared and anxious feelings and withdrew personal emotional involvement by distancing themselves from what they had been trained to do in their nursing education. This resulted in a dehumanized attitude towards patients in their daily practice. Kramer (1974) pointed out that if new nurses are not equipped with realistic expectations and visions of the future, when they face a “reality shock”, they tend to act negatively by distancing themselves from what they are expected to do according to their training. The idea is echoed in Melia’s (1987) concern that some nurses adopt “fitting in” as their future caring style. Attree *et al* (2008) found that students’ feeling of being vulnerable and their needs to “fit in” made them feel unable to challenge unsafe practice. Both of these views aid my understanding of the data. The **Adaptive Staying** behaviour pattern indicates that the potential nursing wastage might happen when the new nurses continue to “fit in” and act towards patients with a dehumanized attitude without proper and timely supervision and management support. Without a motivation for an **Active Staying**, the new nursing workforce lost enthusiasm and commitment in their nursing career.

The key feature of the safety culture is “shared perceptions among managers and staff concerning the importance of safety” (Clarke 1999:185). The support from management and director supervisors is the critical element for creating a culture of patient safety (Feng *et al* 2008). It reflects the ability of individuals and organizations to deal with risk and hazards so as to avoid damage and achieve their goal of “patient safety as first priority”. However, the evidence of the study indicates that the current blame-shame-name safety culture in healthcare organizations has obstructed the possibility of organizational and individual learning from accidents and incidents. Many participants made their individual efforts and hoped to make a difference to the safety and quality of patients’ care during their nursing practice. Martin and Evans (1984) pointed out that nursing staff satisfaction may not necessarily be closely related to the quality of care as seen by outsiders, but is almost a self-adjusting concept which relates itself to the staff’s own view of what is possible for them to achieve under the circumstances with the resources available to them. The participants commented that nurses’ concerns about the safety and quality

of health care were easily ignored by medical professionals and administrators, since nurses are required to keep quiet and work hard under the shortage of nurse.

2.4 Developing the concept of Mismatched Expectations

When the “Mismatched Expectations: Individual vs. Organization” emerged as the first core category from the data, it was noteworthy that there is little consensus in current literature on how expectations are best defined from sociological, psychological, organizational and nursing perspectives.

The definition of “role expectation” which is provided by Biddle (1979:256) makes a useful starting point from which to examine the expectations of nursing both from individual and organizational aspects: “expectations that are structured for the roles of position within a social system”. From Biddle’s perspective of role theory (1979:266), organizations are regarded as “an identified social system that is conducted for one or more tangible tasks in the external environment”. Organizations are usually characterized by “partially shared norms, a task structure, and authority structure and writing documents that support the enterprise” (Biddle 1979:266)

The individual’s expectancy was early defined in expectancy theory (Vroom 1964:17) as “a momentary belief concerning the likelihood that a particular act will be followed by a particular outcome”. The expectancy theory stresses the importance of individual perceptions of reality in the motivational process and suggests that rewards associated with job intrinsic factors are more likely to be perceived as producing job satisfaction (Cole 1996). The expectancy-value model was developed from the expectancy theory in psychology to predict job turnover and job satisfaction. It suggests that when individuals can exercise a degree of personal control over their intrinsic work; they are more likely to be perceived as producing job satisfaction (Cole 1996). The evidence in my study has shown that the values of safety and quality of care comprise the most important aspects of nursing for the participants, which offer nurses intrinsic rewards. Under a highly mismatched expectation of nursing between the individuals and the organization, leaving nursing

practice may be regarded as the best strategy to deal with the stress and dissatisfactions caused by the safety concerns.

The Met-Expectations hypothesis was developed by Porter and Steers (1973). The hypothesis suggests that it is the discrepancy between what individuals encounter on the job and what they expected to encounter that affects their organizational commitment and job satisfaction. Met-expectations are thus operationalized as an algebraic difference between post-entry experiences and pre-entry expectations (Porter and Steers 1973, Wanous *et al* 1992). However, many researchers found inconsistent evidence in support of the met-expectations hypothesis.

By examining the separate and joint contributions of expectations and experiences to the prediction of job satisfaction, organizational commitment and intention to leave during the first year of employment, Irving and Meyer (1994) criticised that the result of previous research investigating the effect of confirmed expectations on work attitudes and behaviour may be misleading because of methodological limitations and an ambiguous conceptualization of met expectations. Their finding provided very little support for the met-expectations hypothesis (Ibid). Taris and Feij (2006) used unmet expectations and work outcomes as a theoretical framework to focus on newcomers' socialisation process among 1477 newcomers from seven Western countries. The study found that unmet expectations contributed longitudinally to a variety of adverse work outcomes, although the finding did not confirm their hypothesis that the relationship between unmet expectations and work outcomes would be moderated through the importance attached to the work aspects. However, as the researchers noted, the data exclusively relied on self-report. Using such a methodological approach, the correlations among concepts which were measured may be limited due to the unreliability of the measurement of intrinsic work value. Based on my finding, I did not agree with the researchers' argument (Taris and Feij 2006:267) that "our larger sample size might compensate for the lack of power due to the reliability".

The two subcategories of “Mismatched Expectations: Individual vs. Organization” in my study coincide with the two main concepts of pre-entry expectations and post-entry experiences in the Met Expectations model. The similarity offers an analytic reminder that it is important to clarify the explicit pre-entry expectations and post-entry experiences of the participants based on the understanding of the relationship between the intrinsic work value of nursing and their intentions of leaving clinical care. However, the concepts in my study did not support the Met Expectations model, which suggests that the confirmation of pre-entry expectation concerning their jobs leads to low levels of voluntary turnover (Wanous *et al* 1992, Irving and Meyer 1995). Taris and Feij (2006) suggested that the process of work adjustment among newcomers extends to the importance attached to various work aspects. My study found that this connection is helpful in understanding the importance attached to safety and quality of health care for Chinese nurses, which does shape their responses to dissatisfaction and stress and orientate their career attitude and behaviour during their nursing practice. The findings of this study supported Irving and Montes (2009), who suggest that to improve work attitudes and lower turnover intentions, the organizational efforts should focus more on providing new recruits with positive work experiences rather than on confirming their pre-entry expectations.

Lait and Wallance (2002) proposed the organizational-professional conflict model to determine how professional and bureaucratic conditions of work influence human service workers’ expectations, and in turn their job stress in Canada. They identify “unmet expectations” as critical in explaining job stress and suggest that the passage of time may result in changes in “professional’s expectations” in regard to their employing organizations, which need to be examined over time, but the data in the study was limited by their cross-sectional design (Lait and Wallance 2002). Maben *et al* (2006) implemented a longitudinal study using naturalistic enquiry to examine the extent to which the ideals and values of the preregistration nursing course are adopted by the new nurses in the UK. The study found that the mismatches between nursing as taught and as practised have a profound impact on the morale, job satisfaction and intention of leaving nursing. The researchers suggested that the

concept of professional-bureaucratic conflicts has potential as an explanatory model in the understanding of the theory-practice gap (Ibid). The view was fully supported by my study and in turn validated the core category which has focused on the interactive expectations between organization and individual. However, Maben and her colleagues continued to emphasise identifying high quality role models, mentorship and perception as key to retention (Maben *et al* 2006, Maben *et al* 2007), which seemed to bypass their initial suggestions that the professional-bureaucratic conflicts may best explain the roots of the theory-practice gap.

Meanwhile, although nursing is formally defined as a professional occupation by almost all nursing professional bodies of the world, whether nursing is a profession, semi-profession or non-profession, has been widely discussed internationally. Yet the answer remains vague from the sociological perspectives of a profession (Freidson 1973, Dingwall 1976, Biddle 1979) based on different nursing education and health care systems. The majority of participants in this study refer to nursing as an occupation which needs hard work and devotion rather than readily accepting nursing as a profession based on their nursing practice experiences. I agree with Dingwall (1976), who advocates that we should abandon any claim to legislate a correct use of the term “profession”, but treat it as a concept invoked by members of particular collectives and seek to describe its practical usage.

To summarize, the concept of expectations in this study is beyond a static concept of role expectations or professional expectations of being a nurse within a broad educational, economic and social context in China. The study found that the individual and organizational expectations of nursing is a continuing, situationally structured, development process through the process of recruitment and the daily interactive nursing practice. Many participants in this study expressed that they left clinical care since they have tried their best, but lost confidence in the safety and quality of patients’ care since the individual and organizational expectations of nursing were highly mismatched. However, the concept of “Mismatched Expectations: Individual Vs. Organisational” alone could not explain why there is a

relatively higher rate of dissatisfaction among Chinese nurses but there is a particularly low rate of actual leaving (Lu *et al* 2007). The study found that the individual perception of power as a nurse within the hospitals not only shapes their experiences of daily practice, but also orientates how the individual nurses respond to the safety concerns, dissatisfaction and stress, which are caused by mismatched expectations of nursing between individuals and organizations.

3. Individual nurses' perception of power

3.1 The meaning of power to nurses

The second core category “individual perception of power” provides further understanding of how the nurses adjust employment behaviour and make a career decision towards leaving nursing practice.

The term ‘power’ has been defined in politics, economics, management and sociology as the idea of “power over” and the “command-obedience relationship” (Weber 1978, Lukes 2005). By recognizing that power is created in relationships, Weber (1978) stresses the capacity to realize the will and suggests that resistance, actual or potential, is relevant to attributions of power. Lukes (2005) suggests that to have power is to be able to make a difference. Therefore how people are affected by the outcomes of this power is crucial in deciding what is important to them, which means the outcome of power must serve the interests of the powerful (Lukes 2005).

Nurses are frequently described as a powerless workforce and current nursing literature proposes nurses should be empowered (Laschinger *et al* 1999, Bradbury-Jones *et al* 2008, Ning *et al* 2009). Kanter’s (1993) theory of organizational empowerment is widely advocated in nursing study, which argues that employees with access to information, support, resources, and the opportunity to learn and grow in their work setting are empowered and able to accomplish organizational goals. I concur with the argument that the term “empowerment” is frequently overused in its application to nurses without a full understanding of nurses’ perception of the power,

both in their working and non-working domains (Gilbert 1995, Leyshon 2002, McGrath 2006). There is a lack of literature that demonstrates explicitly how the dynamics of power or powerlessness relate to the issues faced by the nursing workforce and the orientation of the individual nurses towards leaving.

The methodology of my study was based on a symbolic interactionism perspective. It provided an open chance for the participants to discuss the experience and exercise of power while being a clinical nurse at both the individual and organizational levels. The core category “individual perception of power” emerged from three subcategories: “Nursing autonomy vs. medical dominance”, “Professional value vs. managerial value” and “Personal freedom vs. organizational control”, which has been represented in chapters 6, 7 and 8 respectively. The study found that nurses’ perception of power is a continuing awareness development process that is influenced by the reactions of other key groups with whom nurses interact in their nursing practice within the organization and in their personal life context.

3.2 Nursing autonomy vs. medical dominance

The findings of this study have shown that the experience of working with doctors within the hospital was regarded as one of the key reasons for nurses leaving practice. Many participants who entered nursing before 1999 expressed a common view that “the relationship between doctors and nurses is not as good as before”. The literature has mentioned that gender issues and disruptive behaviour by physicians and contribute to nursing turnover in the UK and USA (Wick 1998, Rosenstein 2002), while the doctor-nurse conflicts seemed not to be the same in China. The conflict with doctors was illustrated by two emergent themes: “Comparing rewards with doctors” and “Struggling with medical dominance”.

It was interesting that in the West the nursing workforce used to be compared with the police workforce or teachers (Mackay 1989), while Chinese nurses used to compare their reward with those of their medical colleagues. The majority of participants complained that an increasingly great gap in financial rewards had

developed between doctors and nurses, while the cost of health services became unaffordable for most patients in China. The evidence of this study suggests that the current social status of nurses and doctors is not as equal as the socialist government advocates it should be, due to their quite different economic status based on the current reward system within the hospitals.

From Freidson's (1986) perspective, the dominance of medical professionals delimits the activities of nearly all allied health professions within the hospitals. However, the Western idea of medical dominance might not be entirely helpful in understanding the current conflicts which are faced by Chinese nurses. The doctors in capitalist countries are socially distinguished from nurses as they normally come from the upper and middle social class and medical students are taught in an academic environment following logical scientific inquiry (Freidson 1970). This contrasts with Chinese doctors and nurses, who have a much more similar academic baseline in their formal education, training, and academic screening for admission than their Western counterparts, particularly since the establishment of the Peoples' Republic of China in 1949 (Orleans 1969, Gao *et al* 1999, Degeling *et al* 2006). Prior to 1978, there were no universally agreed criteria defining who had the right to be called a doctor (Degeling *et al* 2006), which has been described as follows:

Students who have left their medical course unfinished or have been unable to pass examinations often set up as physicians. Graduate or undergraduate nurses also became doctors... Many druggists and sellers of herbs pass as physicians, as also do coolies who have assisted in dispensaries and hospitals. The vast majority of those who practice medicine are from the class of intentional or unintentional deceivers (Cited from Orleans 1969:21).

This means that health workers could be titled "doctor", even without graduating from a medical school. Apart from the "bare foot" doctors¹⁹, medical education in China was delivered through a two-tiered system, with Medical Universities providing a 5 to 6 year long course and Second Medical Schools enrolling high-

¹⁹ "Bare foot" doctors only accept a short and basic medical training without a formal medical education. Two million "bare foot" doctors were trained due to formal medical education being closed and inability to produce enough trained staff to expand primary care provision into rural areas after the Cultural Revolution (1966 -1976).

school graduates in 3 year programmes. Based on their educational, financial and social status, there is certainly a difference in the prestige and dominant position of doctors between the West and China. This difference can be seen in the organizational position of nurses in their respective societies.

For a long time in China nurses and doctors worked together for the benefit of patients with relatively equal social status. Until the late 1990s doctors were paid at a similar level as other clinical staff (Hsiao 2008). The current different levels of medical education are similar to nursing educational background, including the occupational certificate, associate degree, bachelor degree and postgraduate degree of medicine. The state-employed Chinese doctors and nurses are educated and registered by the government but not by the professional bodies.

For several generations of Chinese physicians, loyalty to the state and the ideology of socialism replaced professionalism as an ethical framework (Blumenthal and Hsiao 2005). This also describes the role of Chinese nurses as they were educated within a similar educational system under a medical science orientation. The ideology of socialism in China strongly emphasises that all divisions of health staff are socially equal in working together for the public health service. Chinese nurses are encouraged in their education to devote themselves to serve the public health as the equals of doctors within the hospitals. This ideology does not prepare nursing students for being subordinates to physicians in their real work environment, as Freidson's (1970) declares.

From 1978 to 1999, after the central government cut national health care spending from 30% to 15 %, public hospitals came to function in a way much more influenced by profit (Blumenthal and Hsiao 2005). During the past three decades, the Chinese government has gradually limited public funds for the hospitals, and the bonus payments system was established to complement the regular salary-based reward since 1994. The government modified its salary-based system of compensating hospital physicians to include bonuses, determined according to the revenue the

physicians generated for their hospitals. The role and work of doctors was affected by shifts in the ideological orientations of Chinese government policy (Degeling *et al* 2006). Along with the administrators, doctors regarded themselves as the revenue generators for the hospitals, which are heavily driven by a profit orientation (Degeling 2006). Meanwhile, the financial commitment to medicine from pharmaceutical companies is currently well accepted by doctors as normal. The result has been an explosion in sales of expensive pharmaceuticals and highly technical services. Many participants pointed out that the extra income of the doctors from the pharmaceutical companies was far more than their formal income from the hospital, which became the main cause of the imbalance of financial reward between doctors and nurses. There is keen debate about whether China is genuinely a socialist state or a capitalist state, although it is beyond the remit of this study. It is not surprising that Chinese doctors have been identified as one of “new rich class” (Yang 2008).

All participants reported that Chinese nurses currently have to accept an unnecessarily high workload, such as providing nearly 100% of patients’ intravenous infusions, due to the inevitable over-prescriptions, excessive medication, and over-use of advanced techniques or operations by medical staff. Misuse of antibiotics in China has currently caused serious national and international concern that it would result in severe antibiotic resistance and untreatable infection among the Chinese population (Zhang 2006, Zheng and Zhou 2007, Wang and Wang 2008, Reynolds and McKee 2008, Sun *et al* 2008). This brought ethical dilemmas for nurses who were clinically in sympathy with the situation of patients, but needed to implement the treatment with patients under medical orders. Tang *et al* (2007) found the ethical dilemmas among Chinese nurses in one teaching hospital in southeast China, which included conflicting views on optimal treatment choice meeting with financial constraints and misalignment of nursing responsibilities, competence and available resources. Ethical dilemma was caused when nurses knew what they should do but they did not or could not do it. Attree (2007) reported that English nurses also experienced moral compromise between the economic pressure of the employing organization and patients’ needs. In the UK, the nursing professional code mandates

nurses to raise concerns and make professional judgements based on nursing autonomy and to maintain safety and quality of care (Nursing and Midwifery Council 2002). There are similar professional accountability statements in nursing codes and laws in most developed countries. While over-prescription has been collectively accepted by Chinese doctors as a common practice, all the participants in my study thought that it was impossible for nurses to raise nursing autonomy sufficiently to challenge medical dominance.

Based on nursing education and clinical experience, nurses have the knowledge to understand the patient's situation and medication, and they have more chance to access the patients and multidisciplinary staff, information and facilities within and outside the hospitals, which have become the main resources of power for nurses (Kramer and Schmalenberg 2003, Ceci 2004). Nurses start from a very strong personal power base of wanting to achieve the best outcome of health care (Claus and Bailey 1977, Freidson 1970). However, although the acquisition of authority is not an end in itself, but for the welfare of others, Chinese nurses do not have the right to question the doctors' dominance in giving prescriptions and making clinical decisions.

Having responsibility without promise of power, the covert conflict between doctors and nurses is usually ignored by the medical profession within the hospital. Many participants expressed that the criteria of being a "good nurse" from the doctors' perspective is that the nurses' attitudes and behaviours should be gentle and with enough knowledge to deal with an emergency situation when doctors are not available. The nurse who engages in open conflict might expose herself to a risk of being regarded as a "bad" nurse. Being a good nurse for their medical colleagues has caused the more knowledgeable nurses to be the more disappointed about their education. Although some doctors adapted their attitudes and treatments for the nurses' convenience in their daily practice, they mainly focused on personal relationships and did not actively discuss the conflicts based on the professional

relationship, or work together for the benefit of patients as an effective inter-disciplinary team.

Nurses are required to maintain loyalty to medical staff and maintain harmony within the hospital under a collectivist²⁰ cultural environment. While nursing practice collides with medical dominance, there is no promise of organizational structural power to protect nursing autonomy within the hospital environment. A few participants also criticised that the first Nursing Law, which was issued in 2008, did not actually protect nursing autonomy. Chinese Nursing law asks that nurses should report to doctors first when a doctor's mistake is found, which implicitly forces nurses to take responsibility for halting doctors' mistakes while reinforcing the requirement for nurses to accept medical orders as a rule. Meanwhile, as front line clinical staff, they have to face the deterioration in public trust of the hospital health service and to deal with more patients' complaints about the unreasonably high costs. Many participants had to face ethical dilemma when they failed to meet different patients' needs based on their financial capability according to the organizational requirement and felt disappointed at being "scapegoats", while they personally experienced or witnessed more violence in clinical settings during their daily practice. As a consequence, the majority of current nurses normally accept the powerless status of nursing and keep quiet in order to maintain harmonious work relationships by adhering to the medical dominance, although many clinical nurses may vent their frustration on the medical representatives, who directly carry out business with the physicians.

However, the leavers seemed unready to accept this necessarily powerlessness status. The evidence shows that these leavers not only hoped that their nursing knowledge and skills could be more properly valued by their medical colleagues, but also hoped that they could take more responsibility to exercise nursing autonomy for patient's

²⁰ The collectivism organizational culture in Chinese society is pervasively influenced by Confucian thought and the Doctrine of the Mean, which means the individuals behaviour should be willingness to compromise in keeping with a collective interest in stability and order (Ng 1998).

quality and cost efficacy of care. Autonomy is regarded by Freidson (1973:94) as “the central feature of a profession, that is, the ability of its members to control their own work”. The study found that the gap between theory and practice increased when nurses were equipped with a higher level of nursing education with the ideal of holistic care which required them to exercise nursing autonomy for their practice, but nursing autonomy could not get fully support from their medical colleagues and the hospital managers

While the participants found that it is difficult for them to exercise nursing autonomy in their daily practice and to fulfil their nursing responsibilities under the dominant medical power, they resisted medical dominance in several ways during their interactions with their medical colleagues. Many participants expressed their anger or resentment about unprofessional behaviour and the attitudes of medical staff towards patients. Some participants covertly resisted doctors in their daily practice based on their personal and work relationship with doctors; some nurses might have spoken out occasionally with open complaints or accused doctors when the conflicts were relevant to their own nursing practice. Although several participants did gain respect from the medical staff for their expertise in nursing, few hospitals seriously and systematically set out to encourage the acquisition of authority by those nurses in the organization who have a sense of responsibility, initiative and creativity to expand their power base. The participants commented that nurses’ concerns about the quality of health care and cost efficiency were easily ignored by administrators. The contribution of nursing autonomy and its consequences on the quality of the health service within reasonable cost limits are not publicly acknowledged, the hospital and society take the view for granted that nursing practice is subordinated under medical dominance.

As Claus and Bailey (1977) argued, few health care delivery systems utilize the nurses’ personal authority creatively or treat it as a precious resource. As a consequence, those nurses highly committed to the nursing profession felt ashamed to be a nurse and actively pursued other careers which could offer them greater

satisfaction in their life. Some of them, who believed they had the same knowledge as their medical colleagues, determined to become doctors by completing further postgraduate study in medicine, in order to gain respect and high financial reward. Other participants realized that they could enjoy financial benefits similar to doctors if they became medical representatives working in pharmaceutical companies. Being more aware of medical dominance within the hospital than any outside medical suppliers, the former nurses created medical commitment by cooperating with the doctors and hospital administrators in more invisible ways. By being a doctor or a medical representative to actively pursuing profit, the leavers might not only further deteriorate the reputation of health professionals, but also have a negative impact on successful health care reform, which aims to improve the quality of health care and cost efficiency for the Chinese public.

3.3 Professional value vs. managerial value

When participants started to think: “Should I stay or should I go”, they normally sought support from the nursing managers. The following three themes illustrated that there was a lack of managerial support to maintain nurses who intended to stay in the ideal workplace: “Emphasising nurses as replaceable labour”, “Losing enthusiasm in promotion”, and “Struggling to meet career progress”

The evidence from this study confirms that if their professional value would be appreciated, or even just their hard work acknowledged, by nursing managers, it could delay some participants from leaving. However, many participants felt sad that the nursing managers rarely express appreciation for their efforts to stay and usually avoid acknowledging what the participants have contributed for the patients and the hospitals. Based on the imbalance of power in the employment market between the nurses and the Grade three hospitals, the individual nurse rarely possesses bargaining power equal to their employment status and promotion. According to the managerial view, nurses should work hard to meet the organizational needs since they were well paid by the hospital and they were easily replaced by the new and younger applicants. Although a few managers demonstrated a willingness to ask nurses to

stay in nursing practice, the data have indicated that it is rare for nursing managers to openly discuss possible strategies with the participants in order to encourage their actively remaining in a nursing career. Nearly all participants mentioned that the nursing managers emphasised that nurses leaving nursing was not a problem for the hospital but a negative event for the nurse. The nursing managers and hospital administrators regarded nurses as replaceable labour. McGrath concluded that individual nurses tend to accept their powerless status.

The power that nurses could wield is undermined by fear and a lack of confidence in the value of what they do. Consequently, there is a tendency among nurses to accept the status quo as undesirable but inevitable and to respond as powerless individuals rather than as a powerful group. (McGrath 2006: 327)

Values are enduring beliefs about ultimate goals that are worth striving for (Rokeach 1979). My study supported the view of McGrath that nurses lost ground concerning power if they lost confidence in the value of what they do. However, by focusing on studying why nurses stay rather than leave, McGrath (2006) did not account for whether the leaver and the stayer are in the same powerless status with the same individual perception of power. The data of my study indicates that a more stressful imperative for the majority of participants, who highly value nursing as a profession, is to find a way or space in which they can fulfil their ideals and obligations of nursing to achieve satisfaction at work. The findings of the study echo Chiarella and McInnes' (2008:77) conclusion which was based on analysis of 180 cases of law reports related to the status of the nurses: "both the inability to influence patients' care and unmet needs to feel valued and appreciated contribute to nursing workforce attrition."

For nursing managers, the nurse who most meets the organizational standards is the most "professional". A good nurse is one who accepts the rules of organizations and has completely achieved the requirement of the hospitals. The evidence from the participants' personal experiences indicates that they were expected to know nursing as well as medical knowledge, which is regarded as the most effective way for nurses to gain the medical staff's respect from the nursing managers' points of view. The

participants expressed their understanding that it is a common expectation for them to work hard quietly, and then their work efforts will be properly evaluated by the nursing managers. Under medical academic criteria, nurses are required to pass strict examinations and fulfil essay and publication requirements to compete with medical staff for the limited upgraded posts within the hospitals in order to make career progress. However, the academic requirements for nurses following medical science tend to further undermine the value of nursing. Meanwhile, nursing managers mainly emphasized nursing standards by setting up regular and repeated basic nursing skill tests and strict spot checks. Nearly all participants pointed out that the unprofessional evaluation of nursing performance did not properly value and reward the great efforts they made for safety and quality of care. Furthermore, making suggestions and raising the autonomy of nursing was not encouraged for nurses by nursing managers. As Dingwall (2008:129) comments, “encouraging nurses to think of themselves as professionals introduces an element of self-policing into their practice, with their conscience or ethics as a check on the temptations to cut corners at the expense of patient care.” It provides the ideal situation for employers to exploit nurses’ willingness to work hard and endure whatever is expected of them.

Many participants felt disappointed to realize that the “powerful” nursing leaders actually did not have much authority to protect the rights of nurses and decide the nursing staff levels, since the hospital president and the senior administrators with a medical background remain unchallenged authorities who dominate the nursing managers’ promotion and nursing staff career progress. Because of their limited authority within the organization, it is understandable that the powerless nursing managers strove to secure their position by firmly following the authority line. According to the participants’ comments, the same negative feelings of sacrifice without appropriate rewards for the hard work of nursing were also present among the Chinese nursing managers. The low morale of nursing managers usually means that they are more likely give their personal support and encouragement to their favourite staff who intend to leave. Some participants felt hurt by their nursing managers’ rudeness and dehumanized attitude, which reduced their respect for the nursing managers. The finding suggests that the powerless nursing managers control

their staff and further oppress their own professional value and autonomous nursing practice. As Chavasse (1992:2) declared, “No-one can value others unless they value themselves.”

Several participants truly valued and admired their nursing managers’ hard work through working closely with them, but they also perceived that what they valued in nursing and the contribution of nursing managers has not been properly evaluated by the hospital administrators. Two capable participants had the chance to work closely with the nursing directors due to their managerial preference, but they were still expected to be obedient with no opportunity to openly discuss their expectations of nursing professional status and career development. The lack of communication between the current nursing leaders and the potential nursing leaders of the future initiated the excellent nurses’ thoughts about leaving, as these capable and ambitious groups of nurses eventually lose enthusiasm for seeking promotion by progressing in their careers. There was a lack of a united front in the nursing workforce, among clinical nurses and the nursing leaders, to bargain for professional power in the organization as a professional group.

3.4 Personal freedom vs. organizational control

Many participants frankly admitted that they worried about losing control of their life if they leave their nursing job in the Grade three hospitals, since leaving nursing is a very costly behaviour for Chinese nurses under the organizational control. While the hospital managers emphasised that leaving was an individual problem rather than an institutional problem, Chinese nurses were acutely aware that leaving the hospital usually means permanently leaving a nursing career. The participants continued to adjust their individual expectations of nursing according to their perception of imbalanced power within the organization, which indicates a strong motivation to stay rather than to leave. Two themes emerged from the participants’ account of the organizational controls that negatively influenced nurses’ willingness to stay: “Lack of reasonable nursing mobility” and “Limited maternity and sick leave”

The data show that nearly all participants have thought that they might still work in nursing if they were allowed to work in other units within the hospital. Since there is a lack of transparent and clear information on specific nursing vacancies within the Chinese health care system at local or national level (Chen and Liu 2010), it is impossible for Chinese nurses to directly apply for a specific nursing position based on their personal and professional interests. Therefore, while their personal and professional expectations could not be met in their workplace, seeking an alternative position or work environment became a necessary requirement for the nurses. However, under a situation of general understaffing, the nursing managers regarded these requirements as trouble and tended to avoid whatever nurses explicitly or implicitly raised about mobility as problems. They allocated nurses mainly based on their managerial priority and rarely considered nurses' individual and personal circumstances.

However, compared with the majority of participants who left the hospital due to the lack of nursing managerial support to help them to change their clinical practice units, several participants have successfully managed to transfer their job from nursing practice to non-nursing positions within these hospitals. The study found that the group of leavers who left nursing practice but remained in the hospital *dingbian* system were usually well supported by the hospital administrators or the leaders of the health authority who have dominant power over the nursing managers. It is ironic that this group of leavers were respected by their nursing colleagues as those making the most successful job transition by leaving clinical care, which seemed to attract a collective jealousy among the nurses, and caused further morale deterioration about nursing among the current nursing workforce.

Furthermore, there are many barriers for Chinese nurses wishing to change jobs between the different hospitals. Some participants expressed that they would like to stay in nursing if they could work in another work environment. These participants hope that nursing will be a career for life, but not a job in one hospital. However, the *dingbian* system became the main restriction stopping the permanent nurses from

changing employment. Nearly all participants confirmed that the Grade three hospitals preferred to recruit new graduates with contracts rather than accept experienced nurses from other hospitals within *dingbian*, and they had no interest in welcoming the experienced leavers back. The participants understood that there was a lack of alternative workplaces for their nursing practice which might be better than working in the Grade three hospitals under the current health personnel management control in the Chinese health care system.

However, one new Grade three hospital is an exception. It was funded by a private donation and initially operated with relatively flexible human resource management by adopting the American style of hospital management. It attracted the most ambitious and excellent new graduates, as well as experienced nurses from other hospitals with good English language capability. This hospital was regarded as the most attractive hospital by several participants from different hospitals. Many nurses in the beginning were highly motivated to be professional nurses under the ideals of the American holistic nursing model. However, it was not surprising to learn from the personnel department of the hospital that many nurses had left this hospital in recent years. The participants who left this hospital pointed out that so many highly educated and competent nurses work together, but there were limited career prospects without proper rewards, which became the main force to push the nurses in this hospital to pursue their professional career expectations in nursing by leaving practice in China.

It is unsurprising that many nurses who intended to leave this hospital actively improved their English capability in order to learn or work abroad. However, the evidence shows that this hospital, like other Grade three hospitals, did not welcome the leavers back after they self-funded to obtain higher levels of nursing education from the West. After the participants who previously worked in this hospital personally experienced or witnessed that further learning experiences abroad actually were not appreciated by nursing managers in this hospital, they eventually decided to give up their nursing careers. They commented that it was worthless to pursue further

nursing education in the West if they still wished to practice nursing in China. This hospital as a deviant case further indicates that under the limitation of nursing mobility between the units, hospitals and countries, when the Chinese nurses were encouraged to develop professional expectations of nursing but could not find the most compatible nursing practice environment in which to achieve their professional expectations, they would empower themselves to work abroad as a nurse or seek satisfaction in another field of work.

Meanwhile in order to control unexpected leaving, more punitive personnel policies have been established within the Grade three hospitals. Current Chinese hospital administrators not only forced nurses to accept different employment contracts in order to reduce nursing human resource costs, some hospitals required nurses to pay a high financial penalty of nearly one year's salary if they resigned. Compared with their colleagues who wished to leave nursing practice but could not afford the cost of their leaving, the actual leavers who have paid for leaving the hospitals stated that they did not mind, or even felt happy to pay, the huge penalty for their freedom to leave their employing hospital. The data of this study indicate that the voluntary leavers had better financial or social resources than their colleagues who wished to leave nursing practice but had to passively stay in the job for life. The participants made the final decision to leave only when they felt safe from both a financial and psychological perspective.

Data chapter 4 has indicated that there is a general collective attitude of disapproval towards nurses' voluntary resignation, both from the family and from society, under a highly competitive employment market in China. However, data chapter 8 further illustrated that there was a lack of family friendly policy to balance work-family commitment for the nursing staff in these Grade three hospitals. The hospital managers use administrative power and financial punishment to limit sick leave and maternity leave to a minimum in order to control the increasing trend of absenteeism. Many participants commented that nurses were expected to accept an overload of work when they were in good physical strength during times of understaffing, but,

when they were sick, they were seen as a burden by their nursing managers. Meanwhile, the hospital regarded nurses' family commitments as a personal problem without providing necessary organizational support. Since the work overload and staff shortage, nurses who are in pregnancy or are in their motherhood for breastfeeding often had to carry on their normal shifts and workload without reasonable support. Meanwhile all the Grade three hospitals have closed their child care facilities since 1998 in order to reduce costs, which created great difficulty for the nurses who have preschool children. The participants felt that the well-being of nurses is ignored by the organization, which led them to doubt whether it is worthwhile for them to stay in nursing when it threatens their health and quality of family life.

The full time work schedule, without flexible work hours, and limited maternity and sick leave policy for nursing currently faces great challenges. Nearly all participants got their family support for their leaving. Without positive prospects for the future from the hard work, participants generally accepted themselves as a woman who should take care of their family and abandon their value as nurses.

In order to encourage nurses to work hard without complaining, the government and the hospitals eagerly point out some nurses as good "role models" to demonstrate that these nurses are doing hard, often dirty, work with dedication for patients. Each year during the period from International Labour Day on 1st May to Nurses' Day on 12th May, the media carry many reports on nurses who are awarded a "Labour Medal" both locally and nationally, who insist on doing their duty and working hard even though they are sick or they have difficult personal circumstances. Nurses are encouraged to follow this labour model. A considerable degree of power can be generated by public opinion and the mass media (Freidson 1986). The crucial point is just as Lukes (2005) contends, that the most effective use of power is to prevent such conflicts from arising in the first place by shaping perceptions, cognitions and preferences. In such a way, they accept their role in the existing order of things, either because they can see or imagine no alternative to it, or because they see it as

natural and unchangeable. Therefore, the proud sense of being a nurse among many participants at the beginning of their career gradually collapsed with these powerless images of nursing, which are widely accepted by nurses and by the wider society. The evidence was borne out by many participants, who said that they felt ashamed to talk of themselves as a nurse in their social life before they actually left.

However, the majority of former nurses thought that they actually received respect from nursing managers as well as from nursing colleagues by eventually leaving nursing. The leavers who are successful in their new career became role models for other colleagues who intended to leave. It was common that the leaver was regarded as a “winner” and frequently consulted by the stayers who would have liked to leave but had to stay. However, the leavers who consider returning to their nursing practice in the same hospital, or to low grade hospitals, might be regarded as incapable or “losers”. Other than working in the Grade three hospitals, the alternative employment choice are generally regarded as low paid jobs for the lowly qualified nurses, particularly under the unequal payment for nurses between different grades of hospitals or in the community health care setting, in the countryside and the city. The negative organizational culture towards resignation and possible return to nursing practice further stops leavers actively planning to go back or to work in another work environment even if some opportunities might be available. It could be understood that the participants generally thought that they would not work as a nurse again in another Chinese Grade three hospital.

Many participants regarded their action of leaving nursing practice as “freedom”, by which they eventually escaped from organizational control. According to Pettit’s theory of freedom (2001), the freedom of the person is involved in enjoying a social status that makes the action truly theirs, not an action produced under pressure from others. When someone is said to be free it normally means that they can be held responsible for what they do in the exercise of that freedom; while, when someone is said to lack freedom of will in a certain realm of activity, it implies that they cannot be held responsible for what they do (Pettit 2001). It is interesting that the majority of

the participants regarded the process from the first intention to leave to the actual leaving as an empowering process for freedom. The leavers not only seek possible support from their family and social network, but also pursue advanced non-nursing learning in order to look for a new career, which was regarded by the majority of the participants as an active disengagement²¹ .

The crucial point made from the data analysis is that, in order to pursue their personal freedom, the individual nurses with a higher perception of power realized that they had to give up their hopeless fight for professional nursing status under the control of the organization, which resulted in **Voluntary leaving**; while the nurses with lower perception of power did not have the freedom to make a decision about leaving, and had to accept the powerless status of the current nursing workforce as normal, which resulted in **Passive Staying**.

It is predictable that nurses' personal freedom in current Chinese society will increase in the future. Firstly, the demographic change due to the effects of the one-child policy in China is significant. The one-child generation who were born after 1978 is now becoming the core of the Chinese workforce (Greenhalgh 2008). Growing up in a much more secure and rapidly economically developing society, with more alternative employment chances than the previous generation, the one-child generation attempt to prove their self-worth and value (Yi *et al* 2010). If they do not like their current work environment or workplace culture, colleagues and managers, they are more inclined to resign and look for a more congenial job, which may offer more recognition of their capabilities (Yi *et al* 2010). Secondly, along with the rapid economic development, more and more Chinese families can provide financial support for the female nurses who leave nursing practice while they become the parents of an only child and could not balance work and family life due to limited maternity leave and a lack of flexible work schedules within the hospitals. Thirdly, the new social and health insurance in China has developed to cover the people who

²¹ Disengagement is the process of withdrawing from the normative expectations associated with a

do not belong to any work units. The overall social development has given nurses more freedom than ever before to pursue a different career. Fourthly, Chinese nursing higher education is developing and is highly influenced by the Western professional ideal of nursing, which focuses on increasing critical thinking and nursing autonomy. These demographic, financial, educational and social changes not only predict a declining eligible number of nursing applications, but also mean that, when they enter nursing, they will more likely challenge the current exploitation of the nursing workforce and pursue freedom by leaving nursing practice. Therefore, if the policy makers and the hospital administrators still take organizational control for granted without effective intervention, the imbalance between supply and demand of the nursing workforce in China, and the rate of voluntary leaving, may dramatically increase. Difficulties in nursing recruitment and retention in the future can reasonably be predicted and a higher risk of nursing shortage in China will inevitably cause a serious social problem.

4. Understanding of “Wastage” in resolving nursing shortage

Nursing shortage is a pervasive problem both nationally and internationally, but the current nursing literature on nursing shortage does not fully reflect the fact that nursing shortages might no longer be an issue from a managerial perspective in some relatively affluent metropolitan areas. This is particularly true in Chinese Grade three hospitals, which are the subject of my study.

Data Chapter 3 has indicated rich evidence that the Grade three hospitals can select the well-educated and most qualified nursing graduates since there are plenty of candidates on the waiting list to enter their ideal workplace. Meanwhile, vacancies created by nurses' leaving these hospitals are easily filled. The Chinese Grade three hospital managers take the current surplus of nursing graduates for granted, based on the local, oversupplied employment pool. The imbalance in the distribution of nurses

role and is an essential part of role-exit process (Ebaugh 1988)

is apparent in China due to the inequality of social-economic development and the limitations of the current health care system (Anand *et al* 2008). The inequality of health care workforce distribution exists both in developed and developing countries, although there is a lack of comparative nursing literature to show the degree of difference. In the USA, Brewer (2001) found that the balance in supply and demand for registered nurses varies from state to state and among geographical regions within states. Meanwhile, nurses are often a target for cost-cutting by employers, particularly under the current global economic recession, so it is not surprising that there are not so many clinical practice jobs available in some metropolitan cities, due to a variety of reasons, in different countries (RCN 2011, Spetz 2011, Robert Wood Johnson Foundation 2012). When supply exceeds demand, a surplus exists locally, which has resulted in the educators and registered nurses being concerned about both shortage and surplus (Brewer 2001). However, the causes of relative surplus and the consequences of wastage have not been fully explored in previous literature as an important issue related to the nursing shortage. The high inequality of distribution of doctors and nurses in China has been reported by Anand *et al* (2008) as a critical issue, which also has been indicated in the Chinese health statistical database (MHPRC 2008). It is also noteworthy that the staffing ratio based on the *dingbian* system, which was issued in 1978, may under represent the nursing shortage in China, since the Chinese hospital statistics in nursing staffing lack reliability, which has recently caused serious concern from the policy makers (MHPRC 2010b). It could be understood that although the CNA calls for the hospital to recruit and retain as many nurses as possible to resolve the nursing shortage, the Grade three hospital managers, who have dominant power in setting up the nursing recruitment criteria, do not think that the knock-on effects of the nursing shortage nationwide should be their responsibility. The study found that they are not seriously concerned that nursing shortage is an important issue in their managerial agenda.

The overall turnover literature presumes that the policy makers and hospital managers have a common awareness that retention of staff is an important issue based on the situation of nursing shortage and they imperatively wish to manage turnover effectively (Hayes *et al* 2006). It is understandable that the researchers who

are concerned about nursing turnover assumed that the hospital managers expected to learn different effective strategies to deal with the nursing shortage by retaining the qualified nurses. Nevertheless, this study demonstrates that the Chinese hospital managers did not have a similar awareness and the motivation to retain qualified nurses. The data show that they hold the common view that nurses' leaving is not a problem for the hospitals but an individual problem for the nurses themselves. This popular view may be surprising to Western scholars, who base their view on the decreasing recruitment pool and flexible personnel management within the relative equality of a national health care system.

Data chapter 8 shows that since there is lack of feasible mobility in the Chinese nursing workforce market, the leavers expressed that they were normally aware that leaving was not a reversible process. Under the organizational personnel control, the meaning of leaving nursing practice for Chinese nurses is different from the concept of "nursing turnover" which widely accepted by the current literature. It has caused a great wastage of available nursing human resources. Lu *et al* (2007) report that the rate of satisfaction among Chinese nurses is 53.7%, however, the authors interpret that "more than half" of respondents are satisfied with their job as a positive sign, since "nurses' job satisfaction has received increasing attention and enhancing nurse job satisfaction has been emphasized as a major strategy to recruit and retain qualified nurses in China"(Lu *et al* 2007:584) . However, the positive view cannot logically explain why the nurses who reported high professional (85%) and organizational (63.5%) commitment still expressed high intentions of leaving their employing hospitals (71.9%). This study found that the bachelor degree nurses reported low professional commitment and more stress than the diploma and associated degree nurses, but the authors interpreted from the findings that the reasons for the high professional commitment are: "the Chinese government's recognition of nursing as an independent profession and the development of university degree nursing programs have undoubtedly facilitated an increasing professional status" (Lu *et al* 2007:585). By studying nurses' job satisfaction and related factors, the study still could not explain an overall rate of higher than 70%

having the intention to leave the hospitals in different areas nationwide in China (Sun *et al* 2001, Ye *et al* 2006), which was much higher than the rate of intention to leave in other countries. In a five-country comparison conducted by Aiken and colleagues (2001), Canadian nurses expressed the lowest intention to leave the profession in the next year (16.6%). This compared with Germany (16.7%), United States (22.7%), Scotland (30.3%) and England at 38.9%. By comparing the rate of satisfaction with other countries, the researchers (Lu *et al* 2007) tended to appraise the Chinese nursing workforce management in a positive light, but the researchers could not effectively discuss the deeper root causes of the high intention of leaving. Based on this study, I would argue that the actual rate of voluntary leaving depends on the meaning of leaving for Chinese nurses and how their individual perception of power shapes their responses to dissatisfaction and stress.

Under the organizational control of hospitals in China today, it is understandable that when nurses could not achieve their personal and professional expectations of nursing, some nurses who intended to leave may instead choose to remain in their institutional job for life, which could be defined as **Passive Staying**. This could explain that although a relatively high dissatisfaction and intention of leaving was repeatedly found among Chinese nurses, from a statistical perspective there is only a relatively low rate of nurses who actually have power to leave when compared to the higher rate of nurses' turnover in the West (Lu *et al* 2007).

The literature has demonstrated that a great ratio of inactivity in the nursing workforce has not only occurred in Japan (53.7%), and India (60%) (Nakata and Miyazakis 2008, Gill 2009). Between 12500 and 19123 nurses were employed in occupations other than nursing in Australia during the period 1993 to 1997, some 19.8% of Australian-born people aged 15 to 64 with the highest qualification in nursing, and 14.3% of overseas-born nurses were not in the workplace (Duffield and O'Brien-Pallas 2002). The wastage due to the unemployment and underemployment nurses also existed in some African countries, Canada, Australia and the UK (Spetz 2011). Although there is a lack of statistics in some countries, the evidence still

indicates that increasing nursing educational investment in the past decade seems not to enhance the productivity of the nursing workforce in both developing and developed countries (Brodie *et al* 2004, Dovlo 2005). Dovlo (2005) reported that an inability to realize the full potential of their available workforces has caused internal wastage in African countries. However, the phenomena of wastage has not been fully identified and explored in previous literature as an important issue related to the nursing shortage in different countries. The mainstream literature on nursing turnover struggles to find effective solutions for the shortage, while meeting the target number of registered nurses tends to be the main concern from the perspectives of the nursing educational bodies, clinical institutions and the governments. The reasons may be “because that’s where the money is” as the bank robber explained his action to the court and “but this is where I can see” as with the man who looked for his lost key under the spotlight although he lost it elsewhere, which were analogies vividly used by Clarke (2009:151) to criticise the researchers who conducted staffing-outcomes studies in hospital and kept drawing on administrative data sources of staffing and patient outcomes which were most readily available, but were distant from what the researchers were really interested in examining: staffing as it affects the delivery of direct care.

The findings of my study in Chapter 5 did not support the widely accepted view that low level of turnover is an indicator of good practice (Hayes *et al* 2006, O’Brien-Pallas *et al* 2006). The meanings of leaving which the participants perceived raised some fundamental questions as to how “voluntary leaving” and “passive staying” would differently impact on an effective and sustainable nursing workforce, since both have caused an inevitable nursing wastage. The participants in this study have expressed that the loss of confidence in safety and health care was the main reason for their leaving; while the stayers tend to be more tolerant of the bad practice. The results of my study support the argument that nursing shortage is not merely about numbers, but a matter of how these numbers are effectively deployed in the health care system (Lewis 2002).

From the data, my study has found that different nursing wastage occurred in the Grade three hospitals, which not only has caused the morale of nursing to deteriorate, but also has resulted in a lack of nurses in the remaining employment pool from which lower grade hospitals in less attractive rural areas could recruit. I would argue that wastage is arguably the most pressing and potentially serious crisis for the Chinese nursing workforce management. The study suggests that effective nursing workforce management in resolving shortage should be concerned with the invisible and potential wastage as much as with the visible wastage by voluntarily leaving.

5. Conclusion

By exploring the whole nursing employment process towards their eventual voluntarily leaving of clinical practice, the study found that the nurses with low perceptions of power tend to accept the current powerless status of being a clinical nurses and focus on tasks within the organizational rules by engaging in “**Fitting in**” or **Passive staying**; The nurses with high perceptions of power desire to pursue their individual expectations of nursing by exercising nursing autonomy. If the individual and organizational expectations of nursing are closely matched, they continue to be engaged in **Active Staying**; and, if the individual and organizational expectations of nursing are highly mismatched, they empower themselves for **Voluntary Leaving**.

The rich evidence indicated that expectations of nursing between individuals and organizations have changed historically within a broad educational, economic and social context in China, but mismatched expectations of nursing between the individuals and organizations were continuing to be created, and the degree of mismatching has increased since the hospitals have moved to being driven by a profit orientation under the Chinese health care system. Professionalism in nursing reflects the manner in which nurses view their work and is a guide to nurses’ behaviour in practice to assure patient safety and quality of care (Vollmer and Mills 1966). However, nearly all participants, both experienced and inexperienced former nurses, felt that they had individually failed in their attempts to achieve professional

accountability and they did not trust that the hospitals actually to take the organizational responsibility for patient safety and quality of care. Losing confidence in safety issues became the principal force, and pushed the nurses with a high perception of power to lose their enthusiasm to stay and fight for professional status in the current work environment. It is understandable that they eventually empower themselves to leave nursing practice for personal freedom. The data demonstrated that the voluntary leavers had a higher perception of power to achieve their individual expectation of nursing than their colleagues who wished to leave nursing practice but had to keep a job in nursing for life. In other words, they are more committed to nursing as a profession rather than as an occupation. My conclusion challenges the common managerial view that nurses leave nursing practice because they are lacking in commitment to nursing, which supports the argument of McGrath (2006).

Some might interpret the participants who talked about many safety issues, or even personally experienced accidents, as bad or poor nurses. Therefore they might consider that nurses might actually leave because they are not competitive or as 'good' as the stayers. This might be an issue, but this assumption did not apply to the participant in my study. Actually this issue was implicitly or explicitly posed to the leavers by the interviewees themselves, the people who referred the participants to me, and the nursing managers and nursing colleagues who previously worked with the leavers: "Am I a good nurse?" "Is she or he a good nurse?" "Are you are good nurse?" "Being a good nurse" emerges as a theme. The study found the views of "being a good nurse" are very different from the perspectives of experienced and inexperienced nurses, medical staff, nursing managers and hospital administrators. Following the principle of theoretical sampling, I also conducted several informal conversations with participants' previous colleagues in order to pursue the fulfilment of this theme. I particularly focused on the two participants who had experienced adverse events before they left nursing practice. I was impressed that their nursing and medical colleagues, head nurse and the nursing director described them as even more capable and excellent as they perceived themselves.

It is interesting to note that the majority of studies about nurses' leaving have mentioned that nurses used to complain about poor nursing colleagues' relationships and some nurses "picking on" each other (Mackay 1989, Kleinman 2004, Duddle and Boughton 2007, Kovner *et al* 2007), while this common theme seemed to be missed in my study. None of them has complained that their nursing colleagues contributed to their leaving as other nurses did. From this perspective, it seemed that the leavers may general have felt more powerful than their colleagues. As the data show, the well qualified nurses who passed extremely rigorous selectivity and worked in the Chinese top hospitals would be unlikely to be nurses with poor competence in nursing practice. Nevertheless, the study did not try to argue whether the leavers are bad or good nurses, since this judgement towards individual nurses is beyond the aim of this study and outside the ethical framework.

The evidence from the study has confirmed that **nursing wastage** is not only caused by nurses voluntarily leaving nursing practice, but also occurs when the nurses resort to passive staying, through which they give up nursing autonomy under medical dominance without managerial support. The passive stayers with negative attitudes to nursing may lose confidence in what nurses do. As a consequence, they may not only underestimate the professional values of nursing, but also discourage their nursing colleagues' or nursing students' positive intentions to exercise nursing autonomy. In this way, the passive stayer may undermine the morale of the current and potential nursing workforce and cause **further wastage**.

It is also important to note that nurses' voluntary leaving of clinical care should not be simply interpreted as wastage, because some of them may bring a **possible contribution** to an effective nursing workforce when they still maintain positive attitudes to nursing and are willing to contribute to nursing development with the support of effective retention strategies. The data show that some of them intend to join nursing-related careers later or pursue a further career in community nursing. They also may continue, directly or indirectly, to support their previous nursing

colleagues' efforts at least, whether they are in a non-nursing position within the hospitals or outside of the hospitals. If some of them with a negative attitude to nursing think that they are not suitable to be a nurse anymore and have freedom to leave, this may contribute to a more effective nursing workforce since their leaving not only allows other new fresh nurses to join in, but also helps to stop a possible further wastage by minimizing the negative influence caused by the passive stayers.

The study not only clarified the definition of nursing wastage along with the four nursing behaviour patterns, but has also built a bridge to enable understanding of the relationship between the nurses' voluntarily leaving, nursing wastage and nursing shortage and towards effective nursing workforce management. Based on the explanation and understanding of the behaviour pattern of **Voluntary Leaving**, the study suggests:

1. the higher the degree of mismatch that the nurses recognised between individual and organizational expectations of nursing and the greater the extent of imbalance of power the individual nurses perceived, the more likely it is that the nurses intend to leave the powerless status of being a clinical nurse within the organization.
2. the more difficult it becomes for the nurses to achieve their individual expectations by exercising nursing autonomy in their nursing career, the more likely it is that they actually empower themselves to leave nursing practice.

A further suggestion was based on understanding of the behaviour pattern of **Active Staying**:

An effective nursing workforce can be achieved, when the individual and organizational expectations of nursing are closely matched, and the individual nurses with a high perception of power could achieve their individual expectations by exercising nursing autonomy in their nursing career.

In other words, it suggests that nursing wastage could be avoided if the individual and organizational expectations of nursing were more aligned, and the individual nurses were able to exercise nursing autonomy in their professional practice and career.

The study not only contributes a new theoretical perspective to explain and understand why and how nurses voluntarily leave nursing practice in China, but also provides a way for nurses to communicate the critical nursing wastage problems of the current Chinese nursing workforce management with health policy makers, hospital administrators and nursing managers. The thesis argues that although the low rate of nurses voluntarily leaving nursing practice could be temporary under the Chinese organizational control, the Chinese nursing shortage will become worse, since a continuing wastage exists whether nurses passively stay or voluntarily leave. The hypotheses suggest that only when individual nurses can be empowered with professional autonomy as members of an inter-disciplinary team working in health care can they then take full responsibility both for the benefits of patients and the hospitals by insisting on the professional value of nursing. From the leavers' perspective, the study suggests that effective retention must focus on encouraging nurses' **active staying** in a nursing career rather than to manipulate policy to trap nurses just for **Adaptive Staying** or **Passive Staying**.

6. Limitations and suggestion for further study

The limitation of the study is restricted by the reality of the difficulty in expanding the data collection from different populations and settings following the theoretical sampling. There is a need to further understand the power relationship in nursing workforce management from the nursing managers' perspective, and also from the passive stayers. The verification of the hypotheses seems to be impossible to complete perfectly in a time limited PhD project. Nevertheless, the hypotheses and suggestions warrant verification and are readily modifiable in nursing workforce management within different health care systems by further research. The gender issue did not emerge to explain power relationships in my current study, which might be caused by the limited number of male participants. It needs a further study to investigate how differently the female and male nurses make their career choices. Based on the understanding of nurses leaving nursing practice in this study, it might be worth identifying the group of active stayers in order to understand why and how they reacted differently to their passive staying colleagues in the current health care

work environment, which may facilitate individual learning as well as organizational change towards positive nursing retention. The suggestions further lead to possible implication to initiate effective strategies in maintenance and retention of nursing staff in China. The study advocates that reducing nursing wastage in an effort to resolve the nursing shortage needs full cooperation between nursing educational and health care organizations with proper policy support in China.

7. Implications

7.1 For nursing educators

The study adds an understanding of how the content and context of nursing education have a negative impact on nurses' career decision making in China. The evidence indicates that the nurses who perceive a high autonomy will be more likely to improve the safety and quality of health care and achieve their expectations of nursing; but when the individual and organizational expectation is highly mismatched, there may be a risk that highly educated nurses with unrealistic expectations of nursing simply leave nursing practice or work abroad. Therefore, it is important that the nursing educators should not only lay emphasis on academic aspects of nursing, but also should reconsider the students' recruitment strategies and redesign the nursing curriculum to facilitate students developing realistic expectations of nursing in the clinical setting. Nursing education should help the nurses understand the mismatched expectations and the imbalance in power relationships which inevitably exist and influence their nursing practice within the medical, managerial and organizational context. By discussing relevant issues with teachers, peers, supervisors and professional bodies of nursing, education must help students understand the reality of the situation they will face in nursing practice and enable them to develop effective coping strategies to explicitly express the value of nursing and nursing autonomy.

The study suggests an interdisciplinary learning approach in nursing education, which may provide an effective way for nurses and doctors to communicate and

learn from each other, reduce conflicts with doctors and increase interdisciplinary cooperation. The aim of education focuses on reducing the extent of mismatched expectations of nursing between the individuals and the organizations, but encourages students with vision for the future to exercise nursing autonomy as a profession. There are both great challenges and opportunities for the education providers and hospital managers who must consider how to cooperate and reduce the mismatching expectations and improve the quality of health care to achieve safety and quality in the health service, and thus avoid a more serious risk of nursing shortages.

7.2 For hospital administrators and nursing managers

The study has pointed out that the profit oriented management has caused a great wastage of the best nursing human resource in Grade three hospitals. From the leavers' perspectives, the study provides an understanding of why the top hospitals have the best human resources and facilities, but still the unreasonably high accident rates continue. In order to achieve what the policy makers and hospitals managers advocated, to improve the safety and quality of health care, they should concentrate on empowering nurses to exercise nursing autonomy with organizational and managerial support, rather than always laying emphasis on basic care. My study provides rich evidence that nurses voluntarily leaving nursing should be of great concern to the hospital administrators as a problem for the essential safety of care in hospitals. The hospital management need to encourage staff open discussion and reporting of adverse incidents without fearing blame, which will remove the organizational barriers towards a safer organizational culture in health care.

It suggests that family-friendly employment policy could be a key strategy to keep nurses staying. Providing flexible work hours and reasonable maternity leave may particularly contribute to effective retention for the one-child generation. Along with the Chinese social-economic development and demographic change, family support, with an understanding of nurses' contribution in wider society, is very important for keeping the well qualified nurses in nursing practice. Under the current nursing

shortage, the study suggests that hospital managers might consider recruiting differently educated levels of nurses and care assistants who would improve effective nursing care through skill-mix team work. Meanwhile, the study suggests that a reasonable degree of nursing mobility is important for effective nursing employment, which merits relevant policy support and encouragement.

7.3 For policy makers

By listening to what the participants have said in my study, it may help the Chinese health policy makers understand why the best hospitals have the highest rates of accidents. By creating a discrepancy between the promise of safety and quality of health care and the actual goal of profits, the Grade three hospitals leave nurses to cope with the disappointed expectations of customers. The study provides rich evidence to argue that Chinese nurses have had to work very hard in such complex situations, and it is dangerous that the Chinese policy makers and hospital managers continue only to emphasise basic care without properly supporting nursing autonomy and appreciating the nursing professional contribution for the improvement of safety and quality. It is urgent for the Chinese policy makers and the hospital managers to encourage nursing mobility and effectively employ the well qualified nurses within proper skill-mix team work. To avoid nursing wastage, the retention strategies should consider supporting nurses' active staying in a nursing career rather than trap them into passive staying for life under organizational control.

My study echoes the Mid-Stafford Public Inquiry view that the miserable nurse might struggle for safety and quality of health care with their professional values, but loses hope for change through their individual efforts without nursing autonomy. Powerless nurses are ineffective nurses. It suggests that the well-qualified nurses who continue to voluntarily leave the hospital are a danger signal for both patients and hospitals rather than an individual loss for the nurses themselves, since the problems encountered and created by their departure are continuing affect the safety and quality of health care.

Meanwhile, well qualified nurses choose to leave nursing practice for their personal freedom, which has caused deterioration in nursing morale for both the current and potential Chinese nursing workforce. This will result in more serious nursing shortages in the future, particularly in the lower grade hospitals and rural areas nationwide.

As James Buchan (2006) advocates, nursing shortage is a health system problem, which undermines health system effectiveness and requires health system solutions. There is an urgent need to initiate effective strategies to maintain a stable nursing workforce and attract former nurses back to health care, both locally and nationally, with policy and organizational support. The leavers' experiences that lie behind the statistics should never be forgotten when policies and action plans are being made and implemented in the new health care reform, which aims to improve the safety and quality of health care and establish a harmonious society in China (MOHCPR 2009). Western scholars argue that the loss of nurses from developing countries to developed countries is exploitation (Buchan 2001). I doubt whether the ethical concern about nursing immigration is fully understood in the same context between the developed and developing countries. The evidence in this study indicates that Chinese nurses are encouraged to work abroad by their educational institutions and the CNA, while the nurses who studied or worked abroad are not welcomed back into their original hospitals under current nursing workforce management. It needs to be questioned whether the Chinese government think carefully enough about keeping their precious nursing resource by making a sensitive nursing human resources management plan for the benefit of their public.

As WHO suggests, nursing shortages needs to be thought about internationally but need to be resolved locally. Although the findings are limited to studying the current nursing workforce situation in China, a clear understanding of nurses leaving nursing practice in China will provide an explanation for the nursing shortage internationally from Chinese nurses perspectives. The new theoretical perspective of my study may also contribute to the international debate on nursing wastage and nursing

employment and towards effective nursing workforce management and retention strategies. I would like to conclude the thesis by citing the ideas advocated by the previous President of the ICN at the 2004 Asia Pacific Nursing Congress, reported by Armstrong (2004):

Nursing shortages are not just a problem for nursing. They are a health system problem which undermines health system effectiveness and requires health system solutions. Without effective and sustained interventions, global nursing shortages will persist; undermining attempts to improve care outcomes and the health of nations (Christine Hancock 2004)

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My Bibliography

Education background:

9/2008-	PhD in Nursing	University of Edinburgh
9/2005-7/2006	MSc in Nursing	Queen Margaret University College
9/2000-7/2003	Bachelor Degree in Medicine	Wenzhou Medical College
9/1991-7/1994	Associated Degree in Nursing	Zhejiang Medical University
9/1985-7/1988	Diploma in Nursing	Lishui Health School

Work experience:

9/2006- 7/2008 Nursing College of Hangzhou Normal University, Lecturer, RN

Main duties: to give paediatric nursing lectures and guide students to practice nursing skills.

6/2000-10/2003 Nursing College of Hangzhou Normal University, Lecturer, RN

Main duties: to give paediatric nursing lectures and guide students to practice nursing skills.

8/1988-5/2000 Children's Hospital of Zhejiang Province, RN

Main duties: to participate in clinical nursing, deliver standard nursing care to patients and supervise junior and student nurses working in the hospital.

Semi-structured Interview

Should we look back at your earlier experience from the time you entered nursing until you reach your present stage?

1. Why did you choose nursing study?
2. Can you tell me your experiences in applying for your job in hospitals?
3. How do you perceive the situation working as a nurse?
4. What circumstances initially started your intention to leave?
5. What interaction influenced you to make the last decision about leaving?
6. Can you tell me your experience and feeling in your exit process?
7. What do you think of the change in situation between yourself and your colleagues who are still working in clinical care?
8. In what circumstances, and in which way do you think that leavers may possibly return to contribute their nursing knowledge to Chinese health care again?
9. If someone asks your suggestion for choosing nursing as a career, what would you like to say?
10. Do you have any other concerns about your own or others' leaving nursing practice which I have not yet had a chance to know about?

Do you have any question would like to ask me?

1. 当初，你为什么选择护校护士专业呢？（怎么做出这个选择的？何时毕业于何校？入读什么学校护士专业？在你选择读护校前后对理解护理有什么变化？）
2. 你能谈谈毕业分配或去医院找工作的经历吗？
3. 你怎么看你在医院里做一名护士的处境？
4. 什么事情让你第一次产生离职的念头？
5. 从开始想离职到最后真正离职哪些因素影响你做选择的？
6. 你能告诉我你离职过程中的经历和感受吗？
7. 你怎么看待你现在的境况和那些还在医院护士岗位上工作的同事的境况？
8. 你认为在什么情况下，以什么样的形式可以让那些离职的护士有可能重新利用他们的护理知识或回到护理岗位？
9. 如果你的亲戚朋友向你咨询选择护理专业的意向，你会给他们什么样的建议？
10. 我一直在提问，有没有可能有一些特别影响你自己或者别的护士离职的有关经历或故事，我却没有问到的？

附：你有问题要问我吗？

Information leaflet for Nurses

My name is Junhong Zhu and I have worked as a clinical nurse from 1988 to 2000 before I am working at the Nursing College, Hangzhou Normal University. Now I am a PhD student in the University of Edinburgh and my study is: **A grounded theory study of the process by which nurses leave nursing practice in Mainland China.**

The aim of the study is to understand why nurses leave nursing practice in Mainland China by exploring the process from recruitment to final exit, which based on the ex-nurses' experience and perception of nursing situation during their entering, practising and leaving nursing, and their explanation about the reasons of leaving.

The study hopes the issues created and encountered by departing nurses during their leaving process and its impact on the quality of care would serve as a wake-up call for Chinese society to rethink and re-evaluate the social and economic value of nurses' contribution within Chinese health care system. Hopefully it will stimulate comprehensive nursing retention strategies to improve quality of health care

I am looking for volunteers to participate in the project. Every registered nurse who has left their nursing practice is welcome to take part. You are under no obligation to participate in this study, and if you do, you will be free to withdraw from the study at any stage and you would not have to give a reason.

If you are willing to participate in the interview, your contribution and help will be great appreciated. The study will involve you in attending one interview. The interview will take about one or two hour. I will ask for your permission to audio-record the conversation during the interviews, which basically can help me more concentrate on our conversation. Please feel free to let me know whether you agree or disagree using the record technique.

There is no connection between the project and the health administrative authority. Your personal experiences, perceptions and explanations of your entering, practising and leaving clinical care are particularly valuable for the study. The study involves no foreseeable risks or harm. Your name will be replaced with a pseudonym name, and it will not be possible for you to be identified in any reporting of the data gathered. Furthermore, all recording tapes and transcripts will be kept in a secure place. Only I, the transcriber, and my supervisors have access to all the data. I also will ask for your permission again while I provide the interview transcripts and analysis to you for checking their accuracy. Before completion of the study you will be fully consulted. Therefore, I hope you will feel comfortable about giving your true experience and opinions. Any further concern you may rise before, during and after the interview will be valuable and please do feel free to discuss with me as your wish. If you need to consult any possible questions relevant to the research and the researcher, the following independent consultant who is a lecturer in the nursing colleague of Hangzhou Normal university will answer your enquires.

If you have read and understood this information sheet and you would like to be a participant in the study, please now complete the consent form. I will contact you and we can discuss a suitable time and place at your convenience.

Many thanks for your support!

Yours sincerely,
Junhong Zhu

Contact details of the researcher (in P.R.China and in UK): Mrs Junhong Zhu

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给离职护士有关本研究的信息介绍

我是爱丁堡大学博士研究生朱俊红，目前正在从事关于中国护士离职问题的研究:运用扎根理论分析理解中国护士离职过程。在开始这项研究前，我主要从事临床护理和护理教育工作：1988年至2000年，我是浙江省儿童医院护士（其间三年脱产在浙江医科大学护理系学习）；2000年至去年，我在杭州师范大学护理学院任教（其间两年在英国玛格丽特女王大学硕士研究生学习）。

这项研究，主要目的是通过离职护士回顾自己从事护理职业生涯的各个阶段,包括从开始选择护理职业,从事临床护理工作和最后离职过程中的体验和理解，以及本人对离职作出的解释,以达到对护士离职过程的全面理解。

我希望，通过此项研究,能更好地理解护士离职过程中遇到和关注的问题，以及护士离职对中国医疗卫生质量、护理专业发展,护士自身福利的冲击和影响。我还希望，研究结果可以为进一步出台如何善待护士,保障护士权益，稳定中国护士队伍，提高中国医疗护理的的质量的政策提供具体的依据。

如果您过去是临床注册护士，已经离开临床护理岗位了。无论您现在是否仍然在医院内工作或已经离开医院，我都真诚邀请您参与这项研究。您没有义务参加这项研究，如果你愿意参与这项研究，接受访谈，我将十分感谢你的贡献和帮助。在您志愿参加研究过程中如果你不想继续，您不需任何理由即可从这项研究的任何阶段退出。

这项研究主要是我与你之间的面对面访谈。访谈将持续一至二小时。为了访谈中能集中精力倾听和讨论，同时准确地记录我们的谈话，我希望你能同意我对访谈进行录音。你是否同意录音，也请告诉我。

研究的目的在于评价你的工作能力，也不判断你的职业价值选择。从你进入护士队伍、你的临床实践经历，直到离职，你所有的个人经历、观点和解释，对这项研究具有特别的价值。同时，本人也是一名已经离职的护士，我希望我们可以在访谈中一起共同探讨，以达到更好地理解护士离职问题。

这项研究没有任何可预见的风险或伤害。你的真实名字会用一个代号替换，不会在任何公开报道中出现。而且，所有的录音和笔记都会妥善保存。只有我和我的导师有权查阅这些资料数据。研究结果可能会通过论文，刊物或会议公开发表。同时我会尊重您的个人隐私保密权，在研究完成前我会向你提供您的访谈录音笔记，并充分咨询您的意见，由你确认无误并征得你的同意。因此，我希望你在提供自己的真实经历和观点时不要有任何顾虑。当然，你在访谈前后对任何风险的担心都是可以理解的，请随时提出来和我讨论。

如果你阅读并理解了这个材料，并且你愿意参加这项研究。我会和你联系，根据你的方便确定访谈时间和地点。

非常感谢你的支持！

朱俊红

Consent Form

Towards an understanding of nurses' leaving process in China

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the independent person:

Mrs Fangye Chen
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Telephone: 057128865556(office)
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知情同意书

研究题目:运用扎根理论分析理解中国护士离职过程

1. 我已经阅读并理解该研究的介绍信息和知情同意书,我有机会询问参加研究的相关问题。
2. 我明白我没有义务参加该研究。
3. 我知道在研究过程中如果我不想继续参与,不需要任何理由我有权利从该项研究的任何阶段退出。

我在以上理解基础上, 同意参加该研究。

参与者签名: -----

研究者签名: 朱俊红

日期: -----

研究者联系方式:

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The communication letters about the Ethical Permission in China

(Translation)

Mrs Junhong Zhu

As the vice president, firstly, I would like to thank for your trust in the research Institution of Social Science of Zhejiang Province. The research project you are doing is valuable. However, there is no ethics commitment in our research institution. As I known, there is no requirement for the ethics permission while the researchers apply for their individual research projects in China. Therefore, I suggest that you can apply for ethical approval from the ethical commitment in the University of Edinburgh. Personally, I believe that you will get a satisfied answer according to all your concerning in your application.

Hope your project to be successful!

March 25, 2009

Dr Junchan Wang

Vice president of the research Institution of

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Ethical approval from the University of Edinburgh

(Please see the hard copy in the library)

Appendix 7

Hangzhou health workforce statistics from 2008 to 2010

Year	Annual Patients in the Out-Patients Department		Annual Patients in the In-Patients Department			Total of health staff	Doctors	Nurses	technicians	Managers	supplement workers	Ratio of doctors to nurses	
	Patients in thousand	Rate of Increasing	Patients in thousand	Rate of patients increased	Number of beds increased							Rural and urban areas	urban
2008	61578.2	17.54%	821.6	5.04%	1186	64176	21223 33.07%	18702 29.14%	2941 4.58%	3916 6.10%	4940 7.70%	1.13:1	1.08:1
2009	71518.5	16.14%	993.5	12.24%	2112	68374	22753 33.28%	20997 30.70%	3068 4.49%	3830 5.6%	5206 7.61%	1.08:1	1.03:1
2010	78089.9	9.19%	1116.3	12.36%	2602	74011	24345 32.90%	23418 31.64%	3367 4.55%	3969 5.36%	5558 7.51%	1.04:1	1.00:1
2010 Grade three hospitals²²	24690.9	/	631.4	/	/	/	20566	20949	/	/	/	0.98:1	

²²There are 22 Grade three hospitals (14 hospitals are in the first tier and 8 are the second tier) among 151 hospitals in the total of 2819 health institutions in Hangzhou in 2010. Density per 1000 population, health staff 8.87, doctors 3.53, nurses 3.40. Some data are not readily available because of a lack of availability of official statistics. The information is mainly based on the Hangzhou Health authority statistics online <http://www.hzws.gov.cn/site/> accessed on April 1, 2012.

Appendix 8

The career paths of nurses and doctors in China

Professional posts	Junior posts		Medium Posts	Senior Posts			
doctors	Assistant doctor	Doctor	Doctor-in-charge	Associate professor of medicine		Professor of medicine	
nurses	New nurse (Hushi) ²³	Junior nurse (Hushi)	Nurse-in-charge (Zhuguan Hushi)	Associate professor of nursing (Fu Zhuren Hushi)		Professor of nursing (Zhuren Hushi)	
Pre- registered Education	Diploma/ Associate degree/ Bachelors' Degrees	Diploma/ Associate degree/ bachelors' degree	Diploma/ Associate degree/ Bachelors' degrees	With Bachelor' Degrees	Without Bachelor' Degrees	With Master' Degrees	Without Master' Degrees
Minimum Years of practice	0	3/2/1 according to above educational levels respectively	Previous years + 5	11	20	16	25
Qualified Requirement	National registered examination Hospital examinations	National Registered Examination Hospital examinations	Hospital and Provincial Examinations Essays Publications	Provincial Examinations Publications		Provincial Examinations Publications	

²³ The content of bracket indicates the different name of nursing posts in Chinese.

Publication

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